

2015

An Evaluation of the Raise 5 Project: Preventing HIV and Substance Abuse among African American College Students

Joshua K. Brevard

Virginia Commonwealth University, brevardjk@vcu.edu

Follow this and additional works at: <http://scholarscompass.vcu.edu/etd>

 Part of the [Psychology Commons](#)

© The Author

Downloaded from

<http://scholarscompass.vcu.edu/etd/3797>

This Dissertation is brought to you for free and open access by the Graduate School at VCU Scholars Compass. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of VCU Scholars Compass. For more information, please contact libcompass@vcu.edu.

AN EVALUATION OF THE RAISE 5 PROJECT:
PREVENTING HIV AND SUBSTANCE ABUSE AMONG AFRICAN AMERICAN
COLLEGE STUDENTS

A dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy at Virginia Commonwealth University

By: JOSHUA KYLE BREVARD
Bachelor of Science, Virginia Commonwealth University, 2011
Master of Science, Virginia Commonwealth University, 2013

Director: Faye Z. Belgrave, Ph.D.
Professor of Psychology
Department of Psychology

Virginia Commonwealth University
Richmond, Virginia
April, 2015

Table of Contents

| | Page |
|---|------|
| List of Tables | iv |
| List of Figures | vi |
| Abstract | viii |
| Introduction..... | 1 |
| Literature Review..... | 3 |
| Implementation Summary..... | 29 |
| Strategy I: Evidence Based Interventions | 29 |
| Strategy II: Peer Education and Awareness..... | 34 |
| Strategy III: HIV Testing and Counseling Services | 35 |
| Strategy IV: Social Marketing Campaign..... | 35 |
| Statement of the Problem..... | 36 |
| Methods..... | 37 |
| Preparation | 37 |
| Stakeholder Identification | 37 |
| Evaluator Selection | 38 |
| Definition of the Program to be Evaluated | 38 |
| Evaluation Questions | 39 |
| Process Evaluation Design..... | 40 |
| Measures | 41 |
| Outcome Evaluation Design | 43 |
| Design | 44 |
| Participants..... | 45 |
| Measures | 45 |
| Procedure | 50 |
| Data Analysis Plan..... | 51 |
| Results..... | 54 |
| Findings from Process Evaluation | 54 |
| Question 1: Were the evidence based interventions delivered with fidelity? | 54 |
| Question 2: Did facilitators experience any complications or challenges while delivering interventions?..... | 59 |
| Question 3: What were the participants' views of evidence based interventions? | 61 |
| Question 4: Did the target population attend peer education and awareness events?..... | 64 |
| Question 5: What were students' responses to education and awareness events? | 65 |
| Question 6: Did the target population attend testing events? | 69 |

| | |
|--|-----|
| Summary of Findings from Process Evaluation | 71 |
| Findings from Outcome Evaluation..... | 74 |
| Question 7: Did the Raise 5 Project have adequate retention rates for the evidence based interventions?..... | 77 |
| Question 8: Did participants across all evidence based interventions demonstrate reduced HIV and substance use risk? | 78 |
| Question 9: Did women who participated in SISTA have reduced HIV and substance use risk compared to women in Safe in the City? | 95 |
| Question 10: Did men who participated in Nia have more reduced HIV and substance use risk compared to men in Safe in the City? | 111 |
| Question 11: Did women who participated in Enhanced SISTA have reduced HIV and substance use risk compared to the women in standard SISTA?..... | 121 |
| Question 12: Did African American college students demonstrate reduced HIV and substance use risk? | 128 |
| Summary of Findings from Outcome Evaluation | 131 |
| Discussion | 133 |
| Summary of the Process Evaluation | 134 |
| Summary of the Outcome Evaluation..... | 138 |
| Implications..... | 145 |
| Limitations | 148 |
| Dissemination of Information | 150 |
| Sustainability..... | 150 |
| Recommendations | 151 |
| Conclusions..... | 152 |
| List of References | 154 |
| Appendices | |
| A Peer Education Event Flyers | 171 |
| B HIV Testing Event Flyer | 179 |
| C Stall Seat Journal | 180 |
| D Raise 5 Event Evaluation Survey | 181 |
| E Fan Free Clinic Survey | 184 |
| F Outcome Evaluation Measures | 185 |
| G Intervention Recruitment Flyers | 209 |
| H National College Health Survey | 211 |
| I Observational Report..... | 223 |
| J Facilitator Interviews..... | 225 |
| K Intervention Feedback Evaluations | 237 |
| Vita..... | 245 |

List of Tables

| | Page |
|--|------|
| Table 1. Raise 5 Project Logic Model..... | 23 |
| Table 2. Participant Ratings of SISTA Facilitators..... | 62 |
| Table 3. Participant Ratings of SISTA Sessions..... | 62 |
| Table 4. Participant Ratings of Nia Facilitators | 63 |
| Table 5. Participant Ratings of Nia Sessions | 64 |
| Table 6. Student Reactions to First Three Edutainment Events..... | 67 |
| Table 7. Number and Race/Ethnicity of Students Tested | 71 |
| Table 8. Means and SDs for Demographic Variables for the Three Interventions | 76 |
| Table 9. Frequencies and Percentages of Single Participants across Three Interventions | 76 |
| Table 10. Means and SDs for Outcome Variables | 79 |
| Table 11. Frequencies and Percentages for Outcome Variables..... | 80 |
| Table 12. Outcome Means and SDs for SISTA and Nia..... | 81 |
| Table 13. Unprotected Sex and HIV Testing for SISTA and Nia Participants | 88 |
| Table 14. Means and SDs of Drug Outcomes for SISTA and Nia..... | 89 |
| Table 15. Means and SDs of Outcome Measures for SITC | 91 |
| Table 16. Unprotected Sex and HIV Testing for SITC Participants | 93 |
| Table 17. Means and SDs of Drug Outcomes for SITC..... | 95 |

| | | |
|-----------|--|-----|
| Table 18. | Means and SDs for Outcome Measures at Post-test for SISTA and SITC | 96 |
| Table 19. | Unprotected Sex and HIV Testing at Post-test for SISTA and SITC | 101 |
| Table 20. | Means and SDs of Drug Outcomes at Post-test for SISTA and SITC | 102 |
| Table 21. | Means and SDs for Outcome Measures at Follow-up for SISTA and SITC | 103 |
| Table 22. | Unprotected Sex and HIV Testing at Follow-up for SISTA and SITC | 109 |
| Table 23. | Means and SDs for Drug Outcomes at Follow-up for SISTA and SITC | 110 |
| Table 24. | Means and SDs for Outcome Measures at Post-test for Nia and SITC | 112 |
| Table 25. | Unprotected Sex and HIV Testing at Post-test for Nia and SITC Participants... | 116 |
| Table 26. | Means and SDs for Drug Outcomes at Post-test for Nia and SITC | 117 |
| Table 27. | Means and SDs for Outcome Measures at Follow-up for Nia and SITC..... | 118 |
| Table 28. | Unprotected Sex and HIV Testing at Follow-up for Nia and SITC Participants. | 120 |
| Table 29. | Means and SDs for Drug Outcomes at Follow-up for SISTA and SITC | 121 |
| Table 30. | Means and SDs for Outcome Measures at Post-test for Standard SISTA and Enhanced SISTA | 122 |
| Table 31. | Unprotected Sex and HIV Testing at Post-test for Standard and Enhanced SISTA Participants | 123 |
| Table 32. | Means and SDs for Drug Outcomes at Post-test for Standard SISTA and Enhanced SISTA | 124 |
| Table 33. | Means and SDs for Outcome Measures at Follow-up for Standard SISTA and Enhanced SISTA | 126 |
| Table 34. | Unprotected Sex and HIV Testing at Follow-up for SISTA and Nia | 127 |
| Table 35. | Means and SDs for Drug Outcomes at Follow-up for Standard SISTA and Enhanced SISTA | 128 |
| Table 36. | Sexual Risk Outcomes for African American College Students | 130 |
| Table 37. | Alcohol Use for African American College Students in 2010 and 2014..... | 131 |

List of Figures

| | Page |
|--|------|
| Figure 1. Quasi-Experimental Design | 45 |
| Figure 2. SISTA and Nia Condom Attitude Scores..... | 82 |
| Figure 3. SISTA and Nia Condom Negotiation Scores..... | 83 |
| Figure 4. SISTA and Nia Condom Efficacy Scores | 84 |
| Figure 5. SISTA and Nia HIV Testing Attitude Scores | 85 |
| Figure 6. SISTA and Nia HIV Conspiracy Belief Scores | 86 |
| Figure 7. SISTA and Nia HIV Knowledge Scores | 87 |
| Figure 8. Safe in the City Condom Attitude Scores | 92 |
| Figure 9. Safe in the City Number of Partners Over Past Three Months | 94 |
| Figure 10. SISTA vs SITC: Post-test Condom Negotiation..... | 97 |
| Figure 11. SISTA vs SITC: Post-test Condom Efficacy | 98 |
| Figure 12. SISTA vs SITC: Post-test HIV Conspiracy Beliefs..... | 99 |
| Figure 13. SISTA vs SITC: Post-test HIV Knowledge | 100 |
| Figure 14. SISTA vs SITC: Follow-up Condom Negotiation | 104 |
| Figure 15. SISTA vs SITC: Follow-up Condom Efficacy | 105 |
| Figure 16. SISTA vs SITC: Follow-up HIV Testing Attitudes..... | 106 |
| Figure 17. SISTA vs SITC: Follow-up HIV Conspiracy Beliefs..... | 107 |
| Figure 18. SISTA vs SITC: Follow-up HIV Knowledge | 108 |
| Figure 19. SISTA vs SITC: Follow-up 30 Day Alcohol Use..... | 110 |

| | |
|--|-----|
| Figure 20. SISTA vs SITC: Follow-up Drunk in the Past 30 Days..... | 111 |
| Figure 21. Nia vs SITC: Post-test Condom Attitudes | 113 |
| Figure 22. Nia vs SITC: Post-test Condom Efficacy..... | 114 |
| Figure 23. Nia vs SITC: Post-test HIV Knowledge Scores..... | 115 |
| Figure 24. Nia vs SITC: Follow-up Condom Attitudes..... | 119 |

Abstract

AN EVALUATION OF THE RAISE 5 PROJECT: PREVENTING HIV AND SUBSTANCE ABUSE AMONG AFRICAN AMERICAN COLLEGE STUDENTS

By Joshua Kyle Brevard, M.S.

A dissertation proposal submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2015

Major Director: Faye Z. Belgrave, Professor of Psychology, Department of Psychology

African Americans have been disproportionately affected by HIV since the beginning of the epidemic and the disparities have worsened over time (CDC, 2013a). African Americans comprise about 12% of the U.S. population but represented about 44% of all new HIV infections in 2010 (CDC, 2014a). Young people (age 13–24) accounted for 26% of all new HIV infections in 2010, despite persons in this age range comprising just 17% of the population (CDC, 2014c). Young African Americans (age 13–24) are affected in particular. In 2010, they comprised 57% of infections in this age range (CDC, 2014c). Substance use is a major factor in the sexual risk taking of young people. Substance use has been associated with risky behaviors such as unprotected sex and having multiple partners, which may put one at risk for contracting sexually transmitted infections (STIs) (Kaiser Family Foundation, 2002). This may help to explain why STIs are more prevalent among 18 to 24 year olds than any other age group. Prevalence estimates suggest that young people (age 15–24) acquire half of all new STIs (Satterwhite et al., 2008).

Program evaluation is a social science activity that entails “collecting, analyzing, interpreting, and communicating information about the workings and effectiveness of social programs” (p. 2) (Rossi, Lipsey, & Freeman, 2004). This dissertation is an evaluation of the Raise 5 Project, which aimed to provide HIV and substance abuse prevention services to the African American students attending Virginia Commonwealth University (VCU). The project utilized four strategies: 1) evidence based interventions, 2) peer education and awareness, 3) HIV testing and counseling, and 4) a social marketing campaign. Two forms of evaluation, process and outcome, were utilized to assess the Raise 5 Project. Process evaluation assesses service utilization (i.e., program engagement) and program organization. This process evaluation sought to determine if the project’s four strategies operated as intended. Outcome evaluation assesses the intended outcomes of a program. This outcome evaluation examined if participants in the project’s evidence based interventions had reduced substance use and risky sexual behaviors.

An Evaluation of the Raise 5 Project: Preventing HIV and Substance Abuse among African American College Students

African Americans have been disproportionately affected by HIV since the beginning of the epidemic and the disparities have worsened over time (CDC, 2013a). African Americans currently comprise about 12% of the U.S. population but represented an estimated 44% of all new HIV infections in 2010 (CDC, 2014a). It is currently estimated among African Americans that one in sixteen men and one in thirty-two women will be diagnosed with HIV in their lifetime (CDC, 2014a). African Americans account for more new HIV infections, people living with AIDS, and AIDS related deaths than any other racial/ethnic group in the United States (CDC, 2012a, 2013b, 2013c).

In 2010, women accounted for 29% of the estimated new HIV infections among African Americans, with most (87%) being infected through heterosexual intercourse. The estimated rate of new infections for African American women was 20 times as high as for White women, and almost five times as high as for Latinas (CDC, 2014a). At the same time, males accounted for 70% of new HIV infections among all African Americans. Their rate of HIV infection was seven times as high as for White men, twice that of Latinos, and almost three times that of African American women. Lastly, men who have sex with men (MSM) represented an estimated 72% of new HIV infections among African American men, and 36% of all MSM (CDC, 2014a). African Americans are not only disproportionately infected with the HIV virus; they also suffer more once they have contracted it. For example, HIV-positive African Americans delay seeking care longer than their White counterparts. Among African Americans, HIV progresses to AIDS faster and they die from AIDS sooner than Whites (Turner et al., 2000). Higher rates of HIV is not an isolated phenomenon and African Americans face similar disparities with other sexual

transmitted infections (STIs) such as gonorrhea, chlamydia, and syphilis (CDC, 2010). Over the past three decades researchers have examined contributing factors to these disparities, which include stigma, income, poverty, and access to care (CDC, 2008; Fullilove, 2006; Moseley, Freed, Bullard, & Goold, 2007). Addressing this issue involves identifying the potential barriers to positive health behaviors (e.g., consistent condom use and HIV testing).

Young people often face pressure to simultaneously make decisions regarding substance use and sexual activity. Research has demonstrated that substance use and risky sexual behaviors occur in combination, but it can be unclear which comes first (Eisen, Pallitto, Bradner, & Bolshun 2000; Kaiser Family Foundation, 2002). In particular, alcohol use is an important risk factor for HIV infection which is linked to less frequent condom use and to having multiple sexual partners (CDC, 2013d). Alcohol use is especially salient among college students. In 2012, young adults (age 18-22) enrolled full time in college were more likely than those not enrolled full time (i.e., part-time students and those not currently enrolled) to report current, binge, or heavy drinking. Among full-time students, 60.3% were current drinkers, 40.1% were binge drinkers, and 14.4% were heavy drinkers. Among those not enrolled full time, these rates were 51.9%, 35.0%, and 10.7%. The higher rate of alcohol use among full-time college students is a pattern which has remained consistent since 2002 (SAMHSA, 2013). As such, college students may be more likely to engage in behaviors that place them at risk for HIV infection.

This dissertation is an evaluation of the Raise 5 Project, which was designed to provide HIV and substance abuse prevention services to African American students attending Virginia Commonwealth University (VCU). The literature review which follows discusses the risks of emerging adulthood, HIV and substance abuse risks for college students, along with protective behaviors such as HIV testing and condom use. This is followed by an overview of the Raise 5

Project, which summarizes the literature on the project's four strategies: 1) evidence based interventions, 2) peer education and awareness, 3) HIV testing and counseling, and 4) a social marketing campaign. The literature review concludes with a logic model and an implementation summary for the project.

Literature Review

Risks of emerging adulthood. Most college students are in the developmental period known as emerging adulthood, which spans the late teens to the mid-twenties (Arnett, 2000). This period of self-discovery has tremendous implications, as the decisions made during this time can have a lifelong impact on future well-being. Emerging adults typically decide whether to leave home to attend college, join the armed forces, or find other employment. This can be a stressful experience as a young person's social support (e.g., family, friends, and religious institutions) may no longer be readily available. Most emerging adults do not have children, live in their own home, or have sufficient income to be fully independent. However, these individuals gradually gain greater autonomy and responsibility for themselves. This period can be problematic as emerging adults face a greater likelihood of engaging in risky behaviors such as binge drinking or casual sex (Gillen, Lefkowitz, & Shearer, 2006).

This may explain why STIs are more prevalent among 18 to 24 year olds than any other age group. Compared with older adults, sexually active adolescents (age 15–19) and young adults (age 20–24) are at greater risk of contracting STIs (CDC, 2014b). Prevalence estimates suggest that young people (age 15–24) acquire half of all new STIs (Satterwhite et al., 2013). In regard to HIV, young adults represent the fastest growing group of infected individuals in the United States (Hightow, Leone, MacDonald, McCoy, Sampson, & Kaplan, 2006). Young people (age 13–24) accounted for 26% of all new HIV infections in 2010, despite persons in this age

range comprising just 17% of the U.S. population (CDC, 2014c). Young African Americans (age 13-24) are affected in particular, comprising 57% of infections in this age range in 2010 (CDC, 2014c). Young African American MSM (age 13-24) accounted for 36% of new HIV infections among all MSM. Also, this group was infected with HIV at a higher rate than any other age and racial group of MSM (CDC, 2014a). Due to the high prevalence of STI infection among emerging adults, it is important to understand the risk factors among college students who are in this age range.

HIV risk factors for college students. College is an environment where emerging adults may explore their sexuality for the first time (Fielder & Carey, 2010a). However, college students often engage in risky sexual behaviors. Even more troubling, this population has traditionally been neglected by large scale HIV/STI prevention efforts (Lewis, Miguez-Burbano, & Malow, 2009). Lewis and colleagues (2009) suggest that this omission may be based on the assumption that educational attainment is correlated with greater STI knowledge and the avoidance of risky sexual behaviors. However, Lewis et al. found that greater STI knowledge was not a strong predictor of avoiding risky sexual behaviors. They also found that college students were inconsistent condom users and engaged in a number of other high-risk behaviors (Lewis et al., 2009). These findings support previous work by Scholly, Katz, Gascoigne, and Holck (2005) who found that consistent condom use is not a normative practice among some college students.

College students also engage in other risky behaviors such as having multiple or casual sexual partners (Cooper, 2002). For example, the National College Health Assessment (NCHA) found that among sexually active undergraduate students, 14% of females and 21% of males had sexual intercourse with three or more partners within the past 12 months (ACHA, 2011). This

may be due to decreased expectations of a romantic relationship as the proper context for sexual activity (Stinson, 2010). Consequently, college students may “hook up” or have sex with casual partners with no romantic commitment (Fielder & Carey, 2010a). A number of studies have examined “hooking up” among college students. For example, Fielder and Carey (2010a) found that 33% of their study participants had an oral sex hookup and 28% had a vaginal sex hookup during their first semester, when students are beginning to adjust to college life and social norms. Upward of 81% of college students report hooking up at least once and these interactions often occur with friends or acquaintances (Fielder & Carey, 2010b; Lambert, Kahn & Apple, 2003; Paul & Hayes, 2002). Despite these findings, some researchers disagree about the prevalence of “hooking up” among college students. For instance, Stinson (2010) suggests that hooking up has become a normative practice on college campuses. However, others such as Fielder, Carey, and Carey (2013) propose that hookups are less common than having sex within a romantic relationship.

In addition, researchers have examined the factors which contribute to these risky sexual behaviors. For example, a study examining predictors of HIV risk among college students found that ethnicity, gender, academic status and substance use were significant factors (Dilorio, Dudley, & Soet, 1998). Mehrotra, Noar, Zimmerman, and Palmgreen (2009) found similar results when examining demographic and personality factors in HIV/STI risk perceptions among young adults. Perceptions of risk were higher with casual partners than romantic partners. Univariate analyses demonstrated that a number of factors influenced risk perceptions, including race/ethnicity, gender, sensation seeking, impulsivity, number of partners, and condom use. However, only race/ethnicity, gender, and condom use remained significant in multivariate analyses.

Research has specifically examined risk factors among African American college students. Duncan, Miller, Borskey, Fomby, Dawson, and Davis (2002) found six barriers to safer sex behaviors including negative condom attitudes, partner trust, living in the moment, feelings of invincibility, lack of self-control, and peer pressure. While these barriers were shared by male and female students, women had additional risk factors such as being under the influence of alcohol and other drugs, not realizing the consequences of their actions, and a lack of self-respect. The authors recommended assessing college students' ability to solve problems (i.e., negotiation). In addition, they suggested assessing students' understanding of HIV transmission, alcohol and drug knowledge, and health beliefs (Duncan et al., 2002). These findings suggest that substance use, particularly alcohol, is a major factor in risky sexual behavior.

Substance use, alcohol use and sexual risk. Substance use has been associated with risk behaviors such as unprotected sexual intercourse and having multiple partners, which may put young people at risk for contracting a variety of STIs (Kaiser Family Foundation, 2002). A study by the Kaiser Family Foundation (2002) found that more than a third (36%) of sexually active young people (age 15-24) reported that substance use influenced their decisions about sex. Also, 29% of respondents reported that they had “done more” sexually than they had planned due to substance use. These findings indicate the major role that substance use plays in sexual risk taking. In particular, alcohol use is an important contextual factor that should be considered when examining risky sexual behavior. Alcohol reduces social and sexual inhibitions and can interfere with cognitive processing of information. This can influence sexual decision making and increase the likelihood of risky sexual behavior due to lowered perceptions of risk (Cook & Clark, 2005; Fromme, D’Amico, & Katz, 1999; Norris, Masters, & Zawacki, 2004). The

literature suggests that alcohol use is associated with three major risk behaviors: having casual partners, multiple partners, and engaging in unprotected sex.

First, alcohol has been consistently associated with “hooking up” or having sex with a casual partner (Fielder & Carey, 2010a; Garneau, Olmstead, Pasley, & Fincham, 2013; Lewis, Granato, Blayney, Lostutter, & Kilmer, 2012; Owen, Rhoades, Stanley, & Fincham, 2010). For example, Fielder and Carey (2010b) found that a majority of first-semester hookups (64%) involved alcohol use. Also, alcohol use appears more strongly associated with sexual intercourse hookups than non-coital hookups (Paul, McManus, & Hayes, 2000). Owen, Fincham, and Moore (2011) found that alcohol use was associated with hookups over a four month period among a sample of college students (N= 394). The researchers also found that alcohol use was a stronger predictor for women than men. This suggests that alcohol may increase the likelihood of hookups among women more than men.

Another study found that drinking at fraternity and sorority parties was associated with having casual sex with a stranger (Bersamin, Paschall, Saltz, & Zamboanga, 2012). Justus, Finn, and Steinmetz (2000) suggest that the association between drinking and having sex with strangers is largely explained by the fact that both are correlated with disinhibited personality traits such as excitement. It seems alcohol’s dis-inhibitory effects contribute to an “excuse” function by which college students are able to view their risky sexual behavior as permissible (Leigh & Aramburu, 1996). A qualitative study of college students also found that many used alcohol to explain or justify their hookups or “casual coupling events” (Vander Ven & Beck, 2009).

Second, alcohol use has been tied to having multiple sexual partners. Research suggests that heavy drinkers have more sexual partners than non-heavy drinkers (Graves & Leigh, 1995).

Morrison, DiClemente, Wingood, and Collins (1998) examined the relationship between 30 day alcohol use and HIV risk behaviors among a community sample of 321 African American adults. The researchers found that alcohol use was tied to having multiple sexual partners in the past 30 days. In addition, alcohol use was associated with being male; having a history of STIs, lower HIV knowledge, and greater perceived risk of HIV. Among a majority African American sample (95%) of 671 patients at an urban STI clinic, female binge drinkers were more likely to have multiple sexual partners. In addition, these women were more likely to engage in anal sex and test positive for gonorrhea than those who abstained from alcohol (Hutton, McCaul, Santora, & Erbelding, 2008). Fisher, Cook, Sam, and Kapiga (2008) found similar results with a sample of 1,050 women. The researchers found that the problem drinkers were more likely to have multiple or concurrent sexual partners. Problem drinkers were also more likely to have other STIs such as trichomoniasis vaginalis (Fisher et al., 2008).

Last, alcohol use has been linked to less condom use. In the study previously discussed, Morrison and colleagues (1998) found that greater alcohol use was associated with less condom use and lower condom use self-efficacy. In another study, Wingood and DiClemente (1998) assessed the correlates of consistent condom use among a sample of 128 African American women. They found that the women who consumed alcohol between 20 and 30 days a month were less likely to use condoms (Wingood & DiClemente, 1998).

Research has also found that alcohol use is related to less condom use among women, especially when alcohol use precedes sexual activity with someone other than a main/primary partner (Scott-Sheldon, Carey, Vanable, Seen, Coury-Doniger, & Urban, 2009). Among a sample of 672 African American heterosexual men, binge drinking was associated with having

unprotected vaginal and anal sex with casual female partners. Significant associations were also observed between binge drinking and having had a recent HIV/STI diagnosis (Raj et al., 2009). In a longitudinal study of 393 African American female adolescents, researchers found that high quantity of alcohol use predicted inconsistent condom use. In addition, alcohol use was associated with high sexual sensation seeking, having multiple sexual partners, having sex under the influence of drugs or alcohol, and having anal sex over a 12-month follow-up (Seth, Sales, DiClemente, Wingood, Rose, & Patel 2011). These studies demonstrate that alcohol use is tied to three important risk behaviors: sex with casual partners, having multiple partners, and having unprotected sex. In addition, drinkers tend to be more likely to have a history of STIs. Because drinkers may be at increased risk of HIV, it is important to understand protective behaviors such as HIV testing and consistent condom use.

HIV testing. One of the most important factors contributing to the HIV epidemic is undiagnosed infection. Marks, Crepaz, and Janssen (2006) note that undiagnosed infection is responsible for more than 50% of new infections each year. According to the CDC (2012a) there are an estimated 1,148,200 HIV positive individuals in the United States. About 18.1% (n = 207,600) of this population do not know their status. By continuing to engage in unprotected sex, HIV positive individuals can unknowingly infect others. This makes HIV testing a very important aspect of prevention efforts. Because HIV may not show any physical symptoms, individuals can be unaware of their infection. Regular testing can result in an earlier diagnosis of the virus. Once aware of one's status, HIV positive individuals can begin receiving care. In addition, they can take steps to avoid infecting someone else and reduce the spread of the virus (Frieden, Das-Douglas, Kellerman, & Henning, 2005).

Population-based surveys suggest that African Americans have the highest rate of HIV testing across all racial/ethnic groups. The Kaiser Family Foundation (2014) reports that African Americans and Latinos are significantly more likely to report being tested for HIV than Whites, with 45% of African American and 30% of Latino adults (ages 18 – 64) having been tested for HIV in the last 12 months, compared to just 14% of Whites. Although these findings indicate that African Americans have the highest rates of testing, other research suggests that this may not be the case. For example, one study found that self-reports may actually overestimate testing behavior (Ford, Daniel, Earp, Kaufman, Golin, & Millner 2009). Another study found that 25% of African Americans who reported having a prior HIV test falsely assumed that they were tested during a recent clinical visit (Aragon, Kates, & Greene, 2001). Also, among clinic patients with STIs, African Americans may be less likely to get tested than other racial/ethnic groups (Schwarcz, Spitters, Ginsberg, Anderson, Kellogg, & Katz, 1997).

Several studies have assessed barriers to HIV testing. For example, some research suggest that people do not get tested because they lack information about where or how to get tested for HIV. This lack of knowledge is most prevalent among those who are lower income; less educated, and have never been tested (Ebrahim, Andersen, Weidle, & Purcell, 2004). Other barriers to HIV testing include low perceptions of risk, not acknowledging one's risky sexual behaviors, fears about coping with the results, stigma, and lack of prior HIV testing (Irwin, Valdiserri, & Holmberg, 1996). A recent report by the Washington Post and the Kaiser Family Foundation (2012) found that the most frequent reason for never being tested was low perceived risk (57%). Other prominent reasons for not getting tested are that one's doctor never recommended it (36%), and not knowing where to get tested (12%). HIV testing is very important among young people (age 13-24), as they have the highest percentage of undiagnosed

infection (59.5%). This is not surprising considering the fact that young people tend to believe they are invulnerable to HIV (Demmer & Caroleo, 2001). As such, it is also important to understand other protective behaviors such as condom use.

Condom use. When used consistently and correctly, male latex condoms are a highly effective method for preventing the transmission of HIV (Weller & Davis, 2002). Research also suggests that condoms can reduce the risk of contracting other STIs such as chlamydia, gonorrhea, and trichomoniasis (Holmes, Levine, & Weaver, 2004; Ness et al., 2004). Despite this, there is a widespread lack of condom use among college students. Although approximately 86% of college students report being sexually active, only 35% report consistent condom use during sex (ACHA, 2006; Lewis et al., 2009; Ross & Bowen, 2010). As such, improved understanding of condom use patterns is an important component of HIV prevention efforts (Darbes, Crepaz, Lyles, Kennedy, & Rutherford, 2008; Williams, Wyatt, & Wingood, 2010).

Many studies have sought to understand why emerging adults do not use condoms on a consistent basis. Research suggests that young people (age 13-24 years) are more likely to take risks in comparison to older individuals and are less likely to view themselves as vulnerable to the consequences of their risk taking (CDC, 2012b; Steinberg, 2008). In a study of 155 African American college students, three fourths of the sample reported that they were sexually active (Poulson, Bradshaw, Huff, Peebles, & Hilton, 2008). However, most of the female participants (57%) reported inconsistent condom use. Also, a significant number (44%) would not use a condom if their partner did not want to use one.

El Bcheraoui, Sutton, Hardnett, and Jones (2013) surveyed 824 students at 24 historically Black colleges and universities (HBCUs) and found that over one third of students did not use a condom during their last sexual encounter. The researchers also found that spontaneity of

sexual encounters, low perceptions of HIV risk, and partner-related perceptions were associated with not using a condom during one's last sexual encounter. A study consisting of six focus groups with 54 students from HBCUs in South Carolina and Georgia, found that being in love was a key reason for not using condoms (Thompson-Robinson, Richter, Shegog, Weaver, Sellars, & Brown, 2005). Many female participants noted that they trusted their partner and avoided discussing condom use and HIV risk because they felt it was detrimental to their relationship. These findings demonstrate the importance of increasing condom use among African American college students.

The Raise 5 Project. Research suggests that African Americans are at less risk for alcohol use and abuse than their White counterparts. Among African Americans over age 12, 43.2% used alcohol in the past month, 20.6% were binge users, and 4.5% were heavy users. Among Whites, 57.4% were past month users, 23.9% were binge users, and 7.6% were heavy users (SAMHSA, 2013). In addition, African Americans college students report lower levels of heavy drinking and alcohol-related problems than White students (Chen, Dufour & Yi, 2004; Wechsler, Lee, Nelson, & Kuo, 2002). African American students also report a greater number of "protective behaviors" such as eating before drinking alcohol and counting the number of drinks they consume (Siebert, Wilke, Delva, Smith, & Howell, 2003).

Despite these positive behaviors, the percentage of African American students who reported recent heavy drinking increased significantly from 16.7% in 1991–1992 to 21.7% in 2001–2002 (Wechsler, Lee, Kuo, Seibring, Nelson, & Lee, 2002). It is also important to note that attending a predominantly White university (as compared to a HBCU) increases the rate of alcohol use. Kapner (2008) found that African American students at predominately White colleges and universities are more likely to consume alcohol and binge drink than those attending

HBCUs. However, a concern is that while African Americans have lower rates of alcohol use than Whites, they suffer worse academic, social, and legal consequences (Wallace & Muroff, 2002).

Few studies have examined the potential racial/ethnic differences in alcohol as a contributor to risky sexual behavior. Those that have been conducted have produced inconclusive results. For example, one study suggested that Whites are more likely than African Americans or Latinos to consume alcohol and consequently have sex with a casual partner (Kahler, Read, Wood, & Palfai, 2003). However, Espinosa-Hernandez and Lefkowitz (2009) found no racial/ethnic differences in alcohol use before or during sexual intercourse. This suggests that different groups may share similar risk factors when using alcohol. Also, students across different racial/ethnic groups may have similar rates of engaging in sexual intercourse while consuming alcohol. College students may engage in these types of risky behaviors because emerging adults often have strong feelings of invincibility. As a result, there is an important need for effective substance abuse and HIV/STI prevention efforts within the college population (Cohn, Macfarlane, Yanez, & Imai, 1995).

There is a particular need for prevention efforts among African American college students. As noted previously, African Americans are disproportionately affected by HIV and other STIs such as gonorrhea, chlamydia, and syphilis (CDC, 2010). These health disparities are also present on college campuses and reflect the risk factors found in the general population (Buhi, Marhefka, & Hoban, 2010). While African American students typically have high levels of HIV knowledge, they are still at an increased risk of HIV infection compared to their White peers (Bazargan, Kelly, Stein, Husaini, & Bazargan, 2000; Hightow et al., 2006). As such, the

Raise 5 Project was designed to meet the needs of African American students attending Virginia Commonwealth University.

More specifically, the Raise 5 Project is a capacity-building HIV and substance abuse prevention initiative funded by a grant from the Substance Abuse and Mental Health Services Administration (SAMSHA). The funding for the Raise 5 Project was for five years, from 2010 to 2015. The project's name refers to its five primary goals to promote or raise awareness of 1) HIV; 2) substance abuse; 3) healthy lifestyles; 4) cultural competency; and 5) community empowerment. The Raise 5 Project utilized four program strategies to prevent HIV and substance abuse including 1) evidence based interventions; 2) peer education and awareness events; 3) HIV testing and counseling, and 4) a social marketing campaign. The literature regarding the project's four strategies will now be discussed.

Evidence based interventions. With no sign of a preventive vaccine in the foreseeable future, behavioral risk-reduction interventions offer the best hope for reducing the spread of HIV. Fortunately, research has demonstrated that behavioral interventions can effectively increase preventive practices and reduce risky behaviors. Scientific reviews and meta-analyses suggest that interventions grounded in behavior change theories consistently reduce risky behaviors with effect sizes that exceed those of other health behavior interventions (Kalichman, Carey, & Johnson, 1996). HIV prevention interventions have demonstrated reductions in STIs, new sex partners, substance use during sex, unprotected sex and self-reported pregnancies. Interventions have also been linked to increases in HIV knowledge and greater intentions to use condoms (DiClemente et al., 2004; Jemmott, Jemmott, Braverman, & Fong, 2005, Jemmott, Jemmott, & O'Leary, 2007; Royce, Perlmuter Silverman, & Krauss, 2007).

The interventions that demonstrate the highest reductions in sexual risk behavior and STIs are those that include a skills component (Darbes et al., 2008; Jemmott et al., 2005; Lyles et al., 2007). These interventions are also tailored to the target population in terms of cultural and peer norms (Darbes et al., 2008; Herbst, Kay, Passin, Lyles, Crepaz, & Marin, 2007). Small group interventions that combine education exercises have been effective among a variety of populations, including adults, adolescents, and individuals with serious mental illnesses (NIH Panel, 1997). These types of interventions are especially needed among emerging adults. According to the CDC (2011b) young adults need accurate and age-appropriate information about HIV. This includes learning how to reduce or eliminate risk factors by negotiating safe sex with potential partners. Young adults can also reduce risk by learning how to use a condom properly and by getting an HIV test (CDC, 2011b).

The Raise 5 Project utilized three evidence based interventions to provide risk reduction skills to African American students at VCU: SISTA, Nia, and Safe in the City (DiClemente & Wingood, 1995; Kalichman, Cherry, & Browne-Sperling, 1999; Warner et al., 2008). Sisters Informing Sisters on the Topic of AIDS (SISTA) is an evidence based intervention developed for heterosexual African American women between the ages of 18-29 (DiClemente & Wingood, 1995). The overall objectives of this intervention are to increase assertiveness and condom negotiation skills while promoting ethnic and gender pride and empowerment. Nia is an intervention developed for African American men (ages 18 and older) who have sex with women (Kalichman et al., 1999). The objective of Nia is to enhance the motivation to reduce risky sexual behaviors. This is accomplished by educating participants about the effects of HIV on the African American community and by building skills to recognize and handle risky situations. Safe in the City (SITC) is a single session intervention consisting of a 23-minute HIV/STI

prevention video. Safe in the City aims to increase knowledge and perception of HIV/STI risk; build self-efficacy and skills for safer sex and condom acquisition, negotiation and use.

These interventions are part of the CDC's Diffusion of Effective Behavioral Interventions (DEBI) project (Prather, Fuller, King, Brown, Moering, Little, & Phillips, 2006). With the overarching goal of reducing HIV, the DEBI project is a large scale strategy to bring science based interventions into practice. This is accomplished by providing high quality training and ongoing technical assistance to community-based organizations (CBOs), health departments, capacity-building assistance (CBA) providers and other agencies on science based group and community level HIV prevention interventions. These organizations are conduits for the interventions and have the potential to make a national impact on behavior change among African Americans (Prather et al., 2006).

Peer education and awareness. Emerging adults tend to have good health outcomes. As such, they do not perceive that they are susceptible to health ailments (Fletcher, Bryden, Schneider, Dawson, & Vandermeer, 2007). National polls indicate that a large number of college age individuals do not perceive themselves to be at risk of HIV infection. For example, the Kaiser Family Foundation (2012) surveyed 1,437 young people (age 15–24) and found that almost a third (32%) were not personally concerned about HIV. Over a quarter (27%) were very concerned, 18% were somewhat concerned, and 23% were not too concerned about HIV. In a sample of 130 young people (age 18 – 24), the Washington Post and Kaiser Family Foundation (2012) found that 44% were not concerned at all about HIV infection.

A number of studies have examined HIV risk perceptions among African American college students. For example, Rose (2008) found that among a sample of 222 students, over two-thirds (69%) of participants believed they had no risk of contracting HIV. Another study

assessed HIV risk perception among 5,291 students at seven HBCUs (Thomas et al., 2008). Thomas and colleagues (2008) found that 49% of participants believed that they were at low risk of HIV infection. Twenty percent thought they were virtually at no risk for infection. Among a sample of 860 students at 24 HBCUs, Sutton and colleagues (2011) found that the perception of low HIV risk was more likely among the students with average to high levels of HIV knowledge. There appears to be a knowledge–behavior gap among emerging adults. Although these individuals have high levels of HIV knowledge, it does not seem to translate into engaging in protective behaviors such as consistent condom use (Kanekar & Sharma, 2010; Lance, 2001; Opt & Loffredo, 2004; Winfield & Whaley, 2002). This may be because young adults feel invulnerable to infection due to their relatively high levels of HIV knowledge (Demmer & Caroleo, 2001). These findings demonstrate the importance of increasing risk perceptions among African American college students.

Feelings of invulnerability may be related to the influence of peer norms among college students. Adolescents and young adults are involved in social contexts where peer relationships are prominent and they become involved with groups whose values and norms are perceived as attractive or similar. Consequently, peer norms influence an individual's own behaviors (Crosnoe & McNeely 2008). The influence of peers on behaviors, particularly on drug use and sexual behaviors is well documented (Fang, Stanton, Li, Feigelman & Baldwin, 1998; Norris & Ford, 1998). Theoretically informed HIV prevention programs have acknowledged the association of peer norms and risky sexual behavior through constructs such as subjective norms (Theory of Planned Behavior) or cues to action (Health Belief Model) (Janz, Champion, & Stercher, 2002; Montano & Kasprzyk, 2002).

As such, peers are often used to disseminate health information and education. This practice builds on the natural exchange of information between people of similar age or status (Turner & Shepherd, 1999). Peer education and peer led interventions typically target peer groups and communities rather than individuals as the unit of change. Thus, the agents of change come from within a group or community (i.e. peers) rather than the outside. Also, behavior change is most likely when group members take the lead in change (Aggleton & Campbell, 2000; Campbell, 2004). Peers have been utilized to provide education about health issues such as substance use, sexual behaviors, and HIV/AIDS prevention (Mahat, Scoloveno, De Leon, & Frenkel, 2008; Solomon & Flynn, 2005; Stephenson et al., 2004).

Research indicates that peer education is associated with increases in knowledge (James-Traore et al., 2002; Mahat et al., 2008). The structure of peer education programs vary greatly, including formalized workshops, peer health educators, theater performances, and specialized training for resident assistants or other student leaders (Parkin & McKeganey, 2000; Gould & Lomax, 1993; Shiner, 1999). Peer-led programs have been delivered in schools, clinics, community centers, workplaces, and in informal settings where members of the target populations congregate (Maticka-Tyndale & Barnett, 2010). This form of “education” has been especially popular on college campuses (Brack, Millard, & Shah, 2008). As such, the second strategy of the Raise 5 Project included peer education and awareness programs.

HIV testing and counseling services. In 2001, the CDC issued revised guidelines for HIV counseling and testing, emphasizing the importance of testing in nontraditional (i.e., nonclinical) settings (CDC, 2001). This recommendation was aimed at promoting testing among populations at increased risk and coincided with the approval of rapid HIV tests, which facilitated the expansion of testing in nontraditional environments (Granade, Parekh, Phillips, &

McDougal, 2004). One non-traditional setting of particular interest is college campuses. Surveys of at-risk college students have demonstrated low testing rates and little interest in getting tested for HIV in the future. This has led to recommendations to target all college students in testing programs (Adefuye, Abiona, Balogun, & Lukobo-Durrell, 2009; Maguen, Armistead, & Kalichman, 2000; Morris et al., 2006).

Several studies have examined HIV testing among African American college students. The testing rate across studies ranges from 45% to 59%, indicating that a large number of students are potentially unaware of their HIV status. For example, Opt and Loffredo (2004) found that among their sample of 315 college students, 56% of students who were “somewhat concerned” about HIV had not been tested. Fifty nine percent of students who were “not too concerned” had not been tested. Also, 55% of students who were “not at all concerned” had not been tested. Conversely, slightly over half of the students who reported that they were “very concerned” had been tested.

A study conducted by Rose (2008) found that 45% of the sample (N = 222) had been tested for HIV. Another study with 5,291 students from seven HBCUs found that 59% of the sample had been tested for HIV (Thomas et al., 2008). Payne and colleagues (2006) found 48% of the sample (n = 161) had been tested for this virus. Sutton and colleagues (2011) conducted a study with 1,051 students attending 24 HBCUs and found that 56% of the sample had been tested for HIV. Mancoske, Rountree, Donovan, and Neighbors (2006) examined HIV knowledge, attitudes, and behaviors among 238 students. The researchers found that the students’ knowledge of HIV transmission was relatively accurate and the majority were aware of the sexual healthcare services available to them on campus. However, less than half of the students reported using testing services on campus or in their community.

The widespread lack of testing may be due to a variety of factors. Chng, Carlton and Toynes (2006) found that the most influential factors in HIV testing were confidentiality, nonjudgmental staff, convenience, and cost. Other studies suggest that college students with higher subjective and objective HIV knowledge scores are more likely to be tested than those with lower scores. Also, students with a non-heterosexual orientation were more likely to be tested (Hou, 2008; Hou & Wisenback, 2005). There are also gender differences in testing. Women have higher HIV knowledge scores than men, but are less likely to use HIV testing services on campus, and are less aware of HIV testing services in their community (Chng, Carlton, & Toynes, 2006). These studies demonstrate that the rate of HIV testing is inconsistent among African American college students.

Research has examined the impact of HIV prevention programs on college campuses. For example, the Know Your Status (KYS) (2006-2009) program was a student-led initiative to increase access to HIV testing, counseling, and prevention services among local area college students in North Carolina (Milligan, Cuneo, Rutstein, & Hicks, 2014). The program, run at a four year private university and a two year community college, engaged students by offering free, confidential rapid testing in the colleges' student centers. Testing services offered by KYS were located in convenient and highly accessible student areas, did not require an appointment, was free of cost, and was noninvasive. The high visibility of the program may have reduced stigma and subsequently increased testing rates (Barth, Cook, Downs, Switzer, & Fischhoff, 2002). The implementation of KYS was very effective, increasing the number of tests done by more than fivefold in the first year (Rutstein, Mugavero, Sullivan, Bickers-Bock, & Hicks, 2006). KYS was also successful in recruiting large numbers of untested and at-risk individuals

(Milligan et al., 2014). As such, the third strategy of the Raise 5 Project entailed utilized similar methods to increase rates of HIV testing among African American students at VCU.

Social marketing campaigns. Evidence suggests that social norms are an important predictor of alcohol consumption among college students (Neighbors, Lee, Lewis, Fossos, & Larimer, 2007). Research conducted at several universities has demonstrated that students generally have inaccurate perceptions of how much alcohol their peers drink (Borsari & Carey, 2003; Perkins, Meilman, Leichliter, Cashin, & Presley, 1999). As such, students may feel a greater normative pressure to drink and engage in greater consumption (Perkins, 2003). As noted previously, the use of alcohol may cause students to engage in risky sexual behavior. One method for addressing this issue is social norms marketing. This model is based on the observation that many students misperceive drinking norms. The social norms marketing model has been utilized to reduce risky drinking on college campuses for over two decades (Perkins, 1997; Perkins & Berkowitz, 1986; Perkins, Meilman, Leichliter, Cashin, & Presley, 1999). The primary goal is to correct student's misperceptions about the drinking behaviors of their peers. This is done by measuring and reporting the true behavioral norms to target audiences (Berkowitz, 2005). Consequently, this should reduce the amount of alcohol consumed and the incidence of risky behaviors (Haines & Spear, 1996).

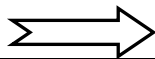
In a multi-site randomized trial of social norms marketing campaigns at nine universities, DeJong and colleagues (2006) demonstrated that students attending institutions with such a campaign had a lower relative risk of alcohol consumption. On some campuses, student affairs officials use a social norms marketing approach to build a climate of support for tougher alcohol policies and stricter enforcement, which most students endorse (DeJong, Towvim, & Schneider, 2008). This work suggests that giving voice to the “silent majority” of students who engage in

healthy behaviors has inspired social marketing campaigns to address other campus health issues such as smoking, drug use, and sexual violence. As such, the final strategy of the Raise 5 Project was a social marketing campaign aimed at providing accurate alcohol consumption information to African American students at VCU. In addition, this campaign also sought to raise awareness of HIV risk among this population.

Logic model. A logic model is a visual representation of how a program is designed to address a specific problem. It demonstrates how a program's activities lead to its desired outcomes (Coffman, 1999). The inputs of a logic model include the plans or resources that make implementation of the program possible. The activities include the training and other program strategies that take place during implementation. Finally, the outcomes are the direct (short and medium-term) and indirect (long-term) changes in behavior and/or conditions as a result of the program strategy.

Table 1.

Raise 5 Project Logic Model

| INPUTS | ACTIVITIES  | OUTPUTS* | SHORT TERM OUTCOMES* | MEDIUM TERM OUTCOMES* | LONG TERM OUTCOMES* |
|---|---|--|--|---|---|
| <p>In order to accomplish its goals, the project would need the following resources:</p> <ul style="list-style-type: none"> • VCU • Center for Cultural Experiences in Prevention (Department of Psychology) • The Wellness Resource Center • Fan Free Clinic • Partnering student organizations • Intervention facilitators • Training in evidence based intervention • (SAMSHA training contractor) • SAMHSA funding | <p>Accomplishing the following activities would result in the following measurable deliverables:</p> <ul style="list-style-type: none"> • Needs assessment • Evidence based interventions • Education and awareness events (e.g., Edutainment events) • HIV testing • Convening Student Advisory Council | <p>Accomplishing these activities would result in the following evidence of progress:</p> <ul style="list-style-type: none"> • 2200 students reached through evidence based interventions, social marketing, education and awareness events, and HIV testing. | <p>The project expected the following measurable changes within the life of the grant:</p> <ul style="list-style-type: none"> • African American students became more aware of HIV risks. • African American students became more aware of substance abuse risks. • African American students would have more positive attitudes towards HIV testing. | <p>We expected the following measurable changes within the next one to three years:</p> <ul style="list-style-type: none"> • More students engage in safer sex practices and get tested for HIV. | <p>We expected the following impacts/trends within the next three to seven years or more:</p> <ul style="list-style-type: none"> • Increase number of HIV infected who know their status • Reduction of HIV among African American college students at VCU • Reduction of substance abuse among African American college students at VCU |

Inputs. The Raise 5 Project made use of several personnel resources in order to accomplish its goals. This effort was led by the Center for Cultural Experiences in Prevention (CCEP) within the Department of Psychology. The Center was established by Dr. Faye Belgrave in 2001 to promote healthy communities by empowering individuals to make positive choices and to change lives through knowledge of self. CCEP's leadership and staff is predominantly African American and its work has been mostly with African American adolescents and young adults. The Center develops, implements and evaluates programs and services that are sensitive to cultural and community needs. The Center has implemented many prevention efforts with African American populations over the past 10 years.

Another key resource was VCU's Wellness Resource Center, which is directed by Dr. Linda Hancock. The Well provides several services to VCU students with the overall aim to promote health and well-being. The staff at the Well utilizes a variety of public health strategies to change student behavior including educational programming, norm-setting social marketing approaches, peer education, policy advocacy, community coalitions, and individual counseling. Also, the staff members at the Wellness Center have become experts in environmental strategies to reach VCU's large population of over 30,000 students. Since 2002, the Well has used social marketing to dispel alcohol use myths on campus. Efforts to establish healthy norms have included the use of primary prevention media, classroom/group sessions with interactive audience response technology, and anonymous online feedback programs for judicially mandated students with alcohol or drug problems.

One of the most effective communication strategies developed by the Well has been the "Stall Seat Journals". Each month, the Wellness Center distributes posters on crucial health topics in over 900 restroom stalls across campus. Process research and market saturation surveys

have consistently shown that the “Stall Seat Journal” reaches over 90% of the VCU population (Porter, 2013). Because of the creative and data-driven interventions conducted by the Well, VCU has received national recognition and has been twice designated by the U.S. Department of Education as a “Model Program for Alcohol and Other Drug Prevention.” In 2005, The Well was awarded a grant to create, evaluate and disseminate findings about alcohol and drug prevention using audience response technology (“clickers”). In 2008, the Well received an award to continue reducing high risk drinking on campus. In particular, the Well conducted a randomized intervention-comparison group study to examine the effect of adding audience response technology to traditional alcohol education classes for judicially sanctioned students. Clicker-enhanced brief live interactive normative group sessions were utilized during Welcome Week to reduce high-risk drinking among first year college students. The Well was nationally recognized in 2010 when it won the “Best Practice Award for College Health Promotion and Prevention.”

Another important resource for the Raise 5 Project was the Fan Free Clinic, a 501(c)3 non-profit organization located in Richmond, Virginia. Founded in 1970, the Fan Free Clinic (FFC) has provided health care services to those who are least served: minorities, men who have sex with men (MSM), injection drug users (IDU) and transgender individuals. Fan Free Clinic provides holistic care through its three distinct and interdependent service areas: Medical Services, Social Services, and Health Outreach. Medical Services are provided for anyone in need of non-specialty services. Social Services provide services to individuals who are in need of case management services or mental health care. The Health Outreach Department of Fan Free Clinic currently provides services to those who are incarcerated, MSM, IDU and

Transgender Populations with special emphasis placed on reaching persons of color with those identified risk factors.

One of the most important services that Fan Free offers is free and confidential HIV testing. When an appointment is scheduled, a brief assessment is conducted to help staff at Fan Free determine the best testing option for an individual. The services are delivered quickly, with test results being available within twenty minutes. Test counselors discuss how the test works, what the test results mean, and make recommendations based on an individual's situation.

A faculty resource was Dr. Joann Richardson, who has expertise in communicating health promotion messages to African American audiences. Dr. Richardson, a faculty in the Department of Kinesiology and Health Sciences, supported all aspects of the project but especially the peer education and awareness strategy by providing advice on effective ways to engage and communicate messages to the target audience.

Also, the African American students at VCU were a major resource for the Raise 5 Project. These included both graduate and undergraduate students. Students marketed and served as peer educators for educational and awareness events. They also recruited for and served as facilitators for the evidence based interventions. Other resources included fraternities, sororities, and student organizations at VCU. This includes Alpha Phi Alpha Inc., Omega Psi Phi Inc., Delta Sigma Theta Inc., NAACP @ VCU, Black Psychology Student Association, and the Black Student Union. These organizations have a commitment to engage in community service, including health promotion activities. These organizations are also committed to educating students on important events or social problems that affect African Americans and other minorities.

Material resources included equipment and supplies, including condoms, penis models, HIV and substance abuse prevention booklets and materials, computer equipment, and incentives and refreshments for participants. Financial resources include the funding from SAMHSA (2010-2015) to conduct this capacity-building initiative. The grant period was five years with about \$298,000 of funding per year (for a total of almost \$1.5 million).

Activities. The first activity included the development of a strategic plan for the project. Members of the student Advisory Council were recruited to help inform the direction of the project. A comprehensive needs assessment was conducted by the evaluation team to determine African American students' need for HIV and substance abuse prevention services at VCU. Once the needs assessment was completed, project staff developed a comprehensive strategic plan and identified the appropriate HIV and substance abuse strategies. The first involved the recruitment of students to participate in three evidence based interventions. The second entailed education and awareness events done in partnership with student organizations. The third strategy was HIV testing and counseling services. The final strategy was a social marketing campaign consisting of "Stall Seat Journal" posters specifically targeted to African American students. These posters were strategically placed in restrooms at university locations frequented by a high percentage of African American students.

Outputs. The primary outputs of the Raise 5 Project included reaching 2,200 African American students through completing one of three evidence based interventions (SISTA, Nia, or Safe in the City), student participation in peer education and awareness events, HIV tests, and the social marketing campaign, across the five years of the project.

Short term outcomes. The short term outcomes for the Raise 5 Project included increased awareness among African American college students of HIV and substance abuse risks. A second short term outcome was more positive attitudes towards HIV testing.

Medium term outcomes. The medium term outcomes of the Raise 5 Project were increases in safer sex practices and HIV testing.

Long term outcomes. The long term outcomes for the Raise 5 Project included 1) increasing the number of HIV positive individuals who know their status, 2) reducing HIV among African American college students, and 3) reducing alcohol and other substance use among African American students.

Summary. The Raise 5 Project is a SAMHSA funded (2010 – 2015) capacity building initiative designed to provide HIV and substance abuse prevention services to African American students at VCU. The resources for this project included the Center for Cultural Experiences in Prevention, VCU's Wellness Resource Center, and the Fan Free Clinic. Other personnel resources included other faculty, students, and student organizations. Material resources included equipment and supplies, including HIV and substance abuse prevention booklets and materials, condoms, computer equipment, and incentives and refreshments for participants.

The project utilized four strategies that were culturally, age, and gender appropriate. The first strategy involved the recruitment of students to participate in three evidence based interventions. The second strategy entailed peer education and awareness events. The third strategy consisted of HIV testing and counseling services. The final strategy was a social marketing campaign that consisted of "Stall Seat Journal" posters for African American students. The short term outcomes of the project were to help African American college students become

more aware of HIV and substance abuse risks. The medium term outcomes were to increase student engagement in safer sex practices and HIV testing. The long term outcomes included 1) increasing the number of HIV positive individuals who know their status, 2) reducing HIV among African American students, and 3) reducing alcohol and other substance use among African American college students.

Implementation Summary

Strategy I: Evidence Based Interventions

This strategy of the Raise 5 Project entailed African American students participating in one of three evidence based interventions: SISTA, Nia, and Safe in the City. SISTA was designed for African American women, while Nia was designed for African American men. Both men and women can participate in Safe in the City. SISTA and Nia are multi-session interventions, while Safe in the City is a single session intervention. As such, participants in Safe in the City served as a comparison group.

A variety of factors were considered when selecting SISTA and Nia. First, both have demonstrated effectiveness in reducing HIV risk among African American men and women. Second, they were chosen because they were specifically developed to target African Americans between the ages of 18-24. Also, these interventions are culturally and developmentally relevant. In addition, these interventions were selected because they consisted of multiple sessions, which were believed to be more effective than a single session intervention. Interventions were delivered over the course of five and four weeks and data were collected at three time points: baseline, post, and 3-month follow-up. Last, while both were developed for

heterosexual African American young adults, the interventions can also be used with lesbian, gay, bisexual, and transgender (LGBT) individuals.

Training of facilitators. Graduate and undergraduate student members of the Raise 5 Project were trained to facilitate SISTA and Nia by CDC certified trainers. As recommended by intervention developers, facilitators had to be African American in order to be trained for SISTA or Nia. The rationale for this race-matching is that research has indicated that race-matching may increase engagement for positive health outcomes among African Americans (Belgrave, Reed, Plybon, & Corneille, 2004; Johnson, Roter, Powe, & Cooper, 2004). The facilitators for Safe in the City did not have to be African American.

SISTA is a gender and culturally relevant group level intervention designed for sexually active African American women between the ages of 18-34 (DiClemente & Wingood, 1995). Five peer-led group sessions focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk reduction behaviors and decision making. The elements of SISTA include 1) small-group sessions with discussions, role playing and skill building activities; 2) peer facilitators who are similar to and who can relate to participants; 3) activities and materials designed to promote ethnic and gender pride; 4) skill building activities in sexual assertiveness and how to negotiate with partners; 5) implementing activities and lessons that encourage favorable condom attitudes and instruct participants how to correctly use condoms; and 6) discussions of cultural and gender issues as they relate to safer sex negotiation and practices. SISTA sessions are led by two African American women who serve as peer facilitators. Each session lasts two hours and the participants met once a week for five weeks. SISTA sessions are designed so that lessons, activities, and practical demonstrations are carried out in a manner that participants can learn from and support one another. An additional booster

session is held three months after the fifth session, before follow-up data collection. During this session, participants share how they have applied the skills and information they learned to their personal lives.

The Raise 5 Project also delivered an adapted version called Enhanced SISTA, which integrated information on substance use. This included information on 1) facts about alcohol and marijuana; 2) impact of substance use on decisions and judgments; 3) impact of substance use on sexual behavior; 4) impact of substance on the body; and 5) legal, social, and academic consequences of substance use.

An evaluation of SISTA indicated that participants reported positive outcomes such as increased condom use, partner communication, and condom negotiation. SISTA participants also had reductions in the number of sexual partners at six month follow-up (DiClemente & Wingood, 1995; Wingood & DiClemente, 2006). The Principal Investigator (PI), Dr. Faye Belgrave had previously used SISTA curriculums with African American women in both college and community samples. Evaluations of these projects revealed increases in intentions and actual condom use, condom negotiation efficacy, and more positive condom attitudes (Belgrave, Corneille, Nasim, Fitzgerald, & Lucas, 2008; Belgrave, Corneille, Hood, Foster-Woodson, & Fitzgerald, 2010). An evaluation of Enhanced SISTA found that participants reported more HIV protective attitudes and less risky sexual behaviors at three month follow-up compared to women in standard SISTA (Belgrave et al., 2008).

Nia is an intervention developed for African American men (ages 18 and older) who have sex with women (Kalichman et al., 1999). The conceptual framework for Nia is provided by the Information-Motivational-Behaviors (IMB) Skills model of HIV preventive behavior change

(Fisher & Fisher, 1992). The overall objective of Nia is to enhance the motivation to reduce risky sexual behaviors. This is accomplished by educating participants about HIV's effect on the African American community and by building skills to recognize and handle risky situations. The intervention was developed to address the fact that heterosexual men may be resistant to condom use, often reacting negatively to requests to use condoms by female partners (Chapman, Stoker, Ward, Porritt, & Fahey, 1990). These men may resist condom use because they do not view HIV as a personally relevant threat. Also, they may value the physical pleasure of unprotected sex more than the safety of condoms (Kalichman et al., 1999). Nia is designed to help men learn new skills to protect themselves and others by promoting condom use and increasing intentions to use condoms (Kalichman et al., 1999).

Nia sessions are led by two African American peer facilitators, one male and one female. The six hour intervention can be carried out in two to four sessions. The Raise 5 Project implemented Nia across four weeks with each session lasting about an hour and a half. The educational, motivational, and skills-building components rely on videos to increase its transportability (Kalichman et al., 1999). The videos are utilized to help generate discussion between participants on a variety of topics, such as the pros and cons of condom use. Participants also learn skills for problem-solving, decision-making, personal risk reduction, and sexual communication. An evaluation of Nia found that intervention participants were significantly more likely than participants in the comparison group to use condoms almost every time they had sexual intercourse (Kalichman et al., 1999). Nia participants were also significantly more likely to talk with a sexual partner about AIDS at the three month follow-up. While these findings were no longer significant at six month follow-up, Nia participants

planned sex ahead of time and discussed condoms with a partner at a greater rate than those in the comparison group.

Safe in the City (SITC) is a 23-minute prevention video originally developed for STI clinic patients in waiting rooms (Warner et al., 2008). The Safe in the City video contains three interwoven vignettes that portray individuals from different racial/ethnic backgrounds and sexual orientations attempting to negotiate safe sex with partners. In between vignettes, two animated video segments feature a “condom-man” who demonstrates how to properly use condoms. Safe in the City is based on Social Cognitive Theory, the Information- Motivation-Behavioral Skills model, and the Theory of Planned Behavior (Harshbarger et al., 2012).

Video interventions such as Safe in the City are a pragmatic way of delivering STI prevention messages due to their relatively low cost and ease of implementation, likely acceptability, and high likelihood of being adopted and sustained. Safe in the City was evaluated in a large-scale two arm controlled trial with long-term follow-up (M = 14.8 months) of approximately 40,000 patients in three STI clinics. Safe in the City was associated with a 9% reduction in STIs among patients who were exposed to the video compared with those who were not. The largest effects were observed among male patients (13% reduction) and those diagnosed with an STI at their first clinic visit (14% reduction).

The Raise 5 Project delivered an adapted version of the intervention, in which a peer facilitator led a short discussion with participants after the video was completed. Participants were asked to discuss the reasons why African Americans are more affected by HIV than other racial/ethnic groups, what can be done to reduce rates of HIV, and ways individuals could keep themselves safe. Participants were also given pamphlets describing the disproportionate rates of

HIV among African Americans. In addition, factsheets were distributed which displayed HIV rates in various regions in Virginia. The discussion generally lasted about twenty minutes.

Strategy II: Peer Education and Awareness

The second strategy of the Raise 5 Project consisted of peer education and awareness events that were designed to be educational and entertaining, thus the name “edutainment”. According to some sources, the term was first “invented” by Dr. Chris Daniels in 1975 (Vladyslava, 2014). Edutainment has been utilized to disseminate public messages concerning a variety of topics including teen pregnancy, cancer, substance abuse, and HIV.

The Raise 5 Project’s edutainment events were developed by a graduate student, Jasmine Abrams, and Dr. Joann Richardson, a faculty member with expertise in community health promotion. The goals of these events were to generate voluntary behavior change among African American students. Events included references to popular culture, positive and relevant messages, traditional and contemporary communication channels and community/campus outreach to stimulate dialogue and debate. Events were hosted by fellow students, in order to present messages that were not one-sided, didactic, or moralistic. Various edutainment formats were used in a series called *Viewpoint: The Black Perspective*. Some topics included “Sex, Drugs, You and Your Boo,” “Sweet Temptations,” and “After the High”. Events also consisted of games (Battle of the Sexes) and skits (Night at the Improv). All events provided educational information about HIV and substance use in an engaging and entertaining way. Events often included guest speakers who were HIV positive individuals who told their personal stories and warned against the dangers of risky sexual behavior (see Appendix A for flyers of these events).

These campus-wide events were hosted once or twice a year by project staff in collaboration with fraternities, sororities, and other student organizations. These organizations

included Delta Sigma Theta Sorority Inc., Alpha Phi Alpha Fraternity Inc., Omega Psi Phi Fraternity Inc., NAACP @ VCU, Black Psychology Student Association, and Black Student Union. Events were also carried out during national HIV awareness days such as the National Black AIDS Awareness Day, World AIDS Day, and National Women and Girls HIV/AIDS Awareness Day. Smaller educational sessions were conducted in residence halls if requested by student organizations or residence hall staff. Information pamphlets, condoms, and other materials were distributed to all attendees. At these events, participants were also recruited to participate in evidence based interventions and encouraged to attend upcoming testing events. Edutainment events were advertised primarily through flyers which were placed in a variety of high traffic areas on campus, such as the Student Commons. Additionally, electronic copies of the flyers were posted on social media sites such as Facebook and Twitter.

Strategy III: HIV Testing and Counseling Services

The third strategy of Raise 5 consisted of HIV testing and counseling services. The VCU Wellness Resource Center and the Fan Free Clinic coordinated this effort. Staff from the Fan Free Clinic offered free HIV rapid testing, counseling, and referrals at the Wellness Resource Center. Additionally, students were referred to Fan Free Clinic (located in close vicinity to VCU) for any other testing needs. Those who tested positive for HIV received follow-up counseling services and Fan Free Clinic staff coordinated referrals for necessary medical treatment. These testing events were advertised on campus through flyers and on social media platforms such as Facebook and Twitter (see Appendix B). Testing events were often held shortly after “edutainment” events, where the testing events were advertised. Although testing was primarily targeted at African American students, all VCU students could be tested.

Strategy IV: Social Marketing Campaign

The final strategy of the Raise 5 Project was a social marketing campaign. In Fall 2011, the Raise 5 Project utilized the “Stall Seat Journal” to distribute information on substance use and sexual behaviors, especially targeting African American students (see Appendix C). This issue of the stall seat journal included statistics on how African Americans are affected disproportionately by HIV. It also provided a brief description of the project, including information about the CCEP. The post also included five tips for students: 1) Getting Tested Annually for HIV, 2) Partying Smart: Buzzed not Bombed! 3) Using Condoms 100%, 4) Creating a Community of Change-Makers and 5) Knowing your Resources. The flyer also describes SISTA, Nia, and Safe in the City and encourages students to participate in the interventions.

Statement of the Problem

This dissertation is an evaluation of the Raise 5 Project, which was designed to provide comprehensive HIV and substance abuse prevention services to the African American students at VCU. VCU is one of the largest universities in the state of Virginia with 31,288 students. About 16% of VCU students are African American. The majority of VCU students are between the ages of 18 and 24 which was the target age for this initiative. African American students attending VCU face many of the same risk factors as their peers in the community. As such, the Raise 5 Project’s comprehensive approach utilized four strategies that were culturally, age, and gender appropriate. The first strategy involved the recruitment of students to participate in three evidence based interventions: SISTA, Nia, and Safe in the City. The second strategy entailed peer education and awareness events. The third strategy was HIV testing and counseling services. The final strategy was a social marketing campaign. These four strategies were carried

out under the direction of project staff and trained peer health educators. This dissertation assessed process and outcome evaluation results for the four strategies.

Methods

Rossi, Lipsey, and Freeman (2004) defined program evaluation as a social science activity that entails “collecting, analyzing, interpreting, and communicating information about the workings and effectiveness of social programs” (p. 2). They also distinguish between two types: process and outcome evaluation. Process evaluation assesses whether a program is operating as intended or according to some standard. Outcome evaluation measures the intended outcomes of a program (Rossi et al., 2004). Both types of evaluations were performed in order to assess the effectiveness of the Raise 5 Project.

Preparation

Several actions had to be completed before beginning this evaluation. First, stakeholders of the project and of the evaluation had to be identified. Also, the person responsible for conducting the evaluation (e.g., either an internal or external evaluator) had to be identified. Lastly, a complete definition of the program to be evaluated (e.g., what it does and does not include) had to be completed prior to initiating the evaluation.

Stakeholder Identification

Rossi and colleagues defined stakeholders as “individuals, groups, or organizations that have a significant interest in how well a program functions” (p. 18). The primary stakeholders for the Raise 5 Project were the African American students at VCU, who were represented by a student led Advisory Council. Other important stakeholders included the project staff, partnering

organizations VCU organizations, (e.g., the Wellness Resource Center), non-VCU organizations (e.g., Fan Free Clinic), and student organizations.

Evaluator Selection

The current program evaluation was conducted by two internal evaluators. Dr. Raymond Tademy served as the Director of Evaluation from 2010 to 2013. During this period, I served as Evaluation Assistant. I was appointed Project Evaluator in 2013, while another graduate student, Sarah Javier, served as Evaluation Assistant during this period. Worthen, Sanders, and Fitzpatrick (1997) noted several benefits to having an internal evaluator, including the fact that this individual would be more knowledgeable about the program and its history, have more familiarity with the stakeholders and their interests and concerns, and have a greater understanding of the organization and its dynamics. Also, an internal evaluator can typically begin the evaluation more quickly and is in a position to advocate for the use of the evaluation findings. However, there are also benefits to having an external evaluator (Worthen, Sanders, & Fitzpatrick, 1997). For example, external evaluators may be more impartial and not have a personal bias or agenda. As such, external evaluators may be more credible to outside audiences. The funding agency, SAMHSA, did not specify whether the evaluator should be internal or external.

Definition of the Program to be Evaluated

Defining and describing the program to be evaluated is a fundamental step in the preparation of an evaluation study (Worthen et al., 1997). The description sets the boundaries of the evaluation (i.e., what it does and does not include) and supports a common understanding among evaluator, client, and stakeholders. Several sources of information were used to develop

the current program description. First, I reviewed the funded grant proposal. Second, I attended regular meetings with project staff. Last, I drew upon my personal knowledge of the project.

Evaluation Questions

Considering both the process and the outcome nature of this evaluation, the following general goals were assessed: program operation and program outcomes. Program operation assessed whether the Raise 5 Project operated as planned, while program outcomes examined if the Raise 5 Project had the desired effects. Before beginning an evaluation, it is important to identify specific questions to guide the evaluation. As such, I utilized the grant proposal as a key resource in developing evaluation questions. This process led to the development of twelve evaluation questions organized under process and outcome evaluations.

Process Evaluation Questions

- 1) Were the evidence based interventions delivered with fidelity?
- 2) Did facilitators experience any complications or challenges while delivering interventions?
- 3) What were the participants' views of the evidence based interventions?
- 4) Did the target population (African American students) attend the peer education and awareness events?
- 5) What were students' responses to the education and awareness events?
- 6) Did the target population (African American students) attend testing events?

Outcome Evaluation Questions

- 7) Did the Raise 5 Project have adequate retention rates for the evidence based interventions?

- 8) Did participants across all evidence based interventions demonstrate reduced HIV and substance use risk?
- 9) Did women who participated in SISTA have reduced HIV and substance use risk compared to women in Safe in the City?
- 10) Did men who participated in Nia have more reduced HIV and substance use risk compared to men in Safe in the City?
- 11) Did women who participated in Enhanced SISTA have reduced HIV and substance risk compared to women in standard SISTA?
- 12) Did African American college students demonstrate reduced HIV and substance use risk?

Process Evaluation Design

The primary goal of the process evaluation was to assess service utilization (i.e., program engagement), program organization, and whether the four strategies of the Raise 5 Project operated as intended. As such, program evaluation staff engaged in systematic observations of all three evidence based interventions to determine whether they were delivered with fidelity (program organization). Also, participant satisfaction surveys were completed by students who attended the Raise 5 Project's peer education and awareness events. These surveys were collected by program evaluation staff following events. The results of participant satisfaction surveys were used to assess whether the project adequately provided HIV and substance abuse information to its target population (service utilization). Surveys were also completed by students who attended the Raise 5 Project's HIV testing events. These surveys were collected by Fan Free Clinic staff and later given to the program evaluator.

Strategy I: Evidence based interventions. In order to assess program organization, evaluation staff engaged in systematic observations of all three evidence based interventions. The goal of these observations was to determine if the interventions were delivered with fidelity. The evaluation also assessed whether peer facilitators experienced any challenges while delivering interventions.

Strategy II: Peer education and awareness. To assess service utilization, evaluation surveys were completed by the students who attended the Raise 5 Project's peer education and awareness events. These surveys were collected by program evaluation staff. The goal was to determine whether the Raise 5 Project adequately provided HIV and substance abuse knowledge and awareness to its target population. These surveys also assessed if they adequately delivered new HIV information to students.

Measures

A Raise 5 Event Evaluation survey (see Appendix D) was given to students who attended the Raise 5 Project's edutainment events. Survey items assessed knowledge of the Raise 5 Project, satisfaction with the event, and what they wanted to see in future events. The surveys had three main sections: 1) the Raise 5 Project, 2) What Did You Think about Our Program? and 3) Future Events. Surveys also included demographic items such as gender, race/ethnicity, major, and class standing.

The first section, the Raise 5 Project, consisted of seven items assessing: 1) if attendees learned new information about the Raise 5 Project, 2) if they intended to share this information with friends, 3) if their friends would be interested in learning more about the Raise 5 Project, 4) if their friends would be interested in attending future Viewpoint: The Black Perspective events,

5) if attendees were interested in finding out more about the Raise 5 Project, 6) if attendees would like to participate in future Raise 5 events, and 7) if attendees would be interested in collaborating with the Raise 5 Project. Items were on a 5 point Likert scale with responses ranging from 1 for “strongly disagree” and 5 for “strongly agree”.

The second section, What Did You Think about Our Program? had thirteen items that examined students’ reactions to the event they had just attended. Topics included whether participants gained new information about HIV and substance abuse, felt this information was valuable, and if they planned to incorporate it into their lifestyle. Other topics included whether it was interactive, entertaining, and appropriate for college students.

The final section, Future Events, consisted of five items, assessing how to improve events for the future. These items include: 1) how did you find out about this event? 2) What would be the best way to inform you or your friends about similar future events? 3) If you were going to personally inform your friends about similar future events, how would you inform them? 4) Would you be interested in participating in similar future events? 5) If so, how often would you be interested in attending these events? For these items, attendees checked the response that best represented their opinion. If the attendees had more than one response, they could use “1” to indicate their first preference, “2” for their second preference, “3” for their third preference, etc.

Strategy III: HIV testing and counseling services. In order to assess utilization of HIV testing and counseling services, brief surveys were completed by the students who were tested for HIV. This survey gathered data on the number and demographic characteristics of the students tested. It also assessed the risk factors of students who received an HIV test. Data were collected by Fan Free Clinic staff and later given to evaluation staff.

The Fan Free Clinic (FFC) (see Appendix E) survey had three items. The first asked respondents to note whether they had the following HIV risk factors: 1) having multiple sexual behaviors, 2) having sex with someone they did not know very well, 3) the sexual history of their current partner, 4) testing positive for another STI in the last 12 months, 5) having sex with someone whose HIV status they did not know or were not sure about, and 6) knowing or suspecting that one of their partners was having sex with other people. Respondents could check all of the responses that applied for them. The second item asked respondents to check the reasons why they attended the testing event: 1) they came with a partner, 2) they came with a friend, 3) came to be educated about their status, or 4) other. Once again, respondents could select all the response that applied for them. The final item assessed whether drugs or alcohol caused the respondents to: 1) have unprotected sex or 2) have sex with an anonymous partner/someone they did not know every well. Participants could check all that apply. The survey also included demographic items for race and gender.

Outcome Evaluation Design

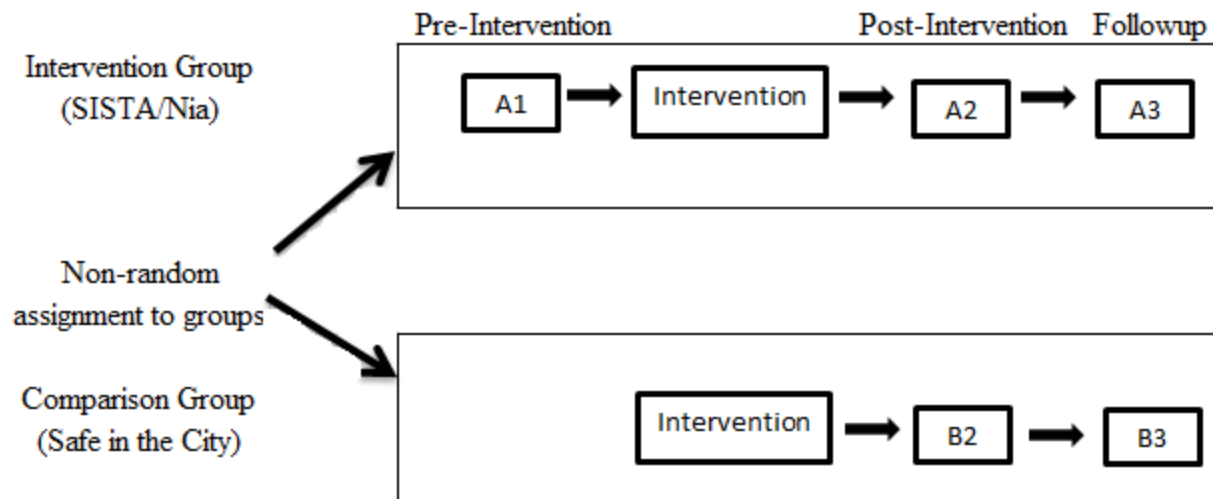
The outcome evaluation has two goals. The first was to assess the effectiveness of participating in evidence based interventions. As such, it assessed whether or not participants had reduced substance abuse and risky sexual behaviors. This evaluation also assessed if participating in multi-session interventions was more effective than the single session intervention. Measures assessed a variety of outcomes, including condom use, efficacy, attitudes, and negotiation (see Appendix F). There were measures of drug use and sexual behaviors over the past 30 days as well as a measure of whether or not the participant had received an HIV test. There were also measures of drug and alcohol use. Data were collected at three time points: pre-test, post-test, and three month follow-up for participants in SISTA and

Nia. Data collection occurred at post-test and follow-up for Safe in the City participants. The second goal was to determine if the social marketing campaign (in combination with the peer education and awareness events) led to a change in the attitudes and behavior of African American students. In order to answer this question, data from the American College Health Association's (ACHA) National College Health Assessment was examined. Data from the years 2010 and 2014 were compared.

Design

Strategy I: Evidence based interventions. Two designs were used. First, a within groups design was utilized to make comparisons (pre-test vs. post-test, post-test vs. follow-up) across all three interventions. Secondly, a quasi-experimental design was used (see Figure 1 below). The intervention group consisted of two multi-session interventions: SISTA and Nia. The comparison group, consisted of a single session intervention, Safe in the City.

Strategies II and IV: Peer education events and social marketing campaign. The effectiveness of the Raise 5 Project's peer education events and the social marketing campaign was assessed using data from the revised National College Health Assessment (ACHA-NCHA II). More than 825,000 students from over 550 colleges and universities across the country have taken the survey. Since 2008, the online version of this standardized instrument has been randomly emailed to approximately 5,000 VCU students from the Registrar's enrollment lists, which includes freshmen through graduate students. Response rates typically are between 30 - 37% and sample sizes typically range between 1,400 and 1,800. Each year, the VCU Institutional Review Board reviews and approves this project. Students' responses on select measures of the ACHA-NCHA II were compared for the years 2010 (the year before the project began) and 2014 (the final full year of the project).



A1 = Pre-intervention data collection points
A2, B2 = Post-intervention data collection points
A3, B3 = Follow-up data collection points

Figure 1. Quasi-Experimental Design

Participants

Strategy I: Evidence based interventions. Participants were recruited using a variety of methods. Staff members recruited participants by posting flyers at the Student Commons and residence halls (See Appendix G). Other methods included e-mail, word-of-mouth, peer education and awareness events, and through social media platforms. Interested individuals gave their contact information to project staff and were enrolled in one of the three interventions based on both inclusion criteria and consent. Inclusion criteria were based on the intervention participants were recruited for. The inclusion criteria for SISTA were that participants were female, identified as African American, and were over the age of 18. Similar criteria were utilized for Nia, except that participants had to be male. For Safe in the City, inclusion criteria were that the participant identified as African American and was over the age of 18.

Measures

Strategy I: Evidence based interventions. National Minority SA/HIV Prevention Initiative Adult Questionnaire was developed by the Center for Substance Abuse Prevention (2009). All SAMHSA grantees were required to have their intervention participants complete this questionnaire and submit data to the National Outcomes Measurement System (NOMS). This questionnaire has three main sections: 1) Facts about You, 2) Attitudes & Knowledge and 3) Behavior & Relationships. Measures on the CSAP questionnaire examined in Raise 5 Project's evaluation will be discussed. These measures include sex and substance use behaviors and attitudes. The first section, Facts about You, includes sixteen demographic items such as gender, age, race, sexual orientation, and education level.

The second section, Attitudes & Knowledge, assesses respondents' risk perceptions regarding certain drugs and sexual behaviors. It also includes items that assess the HIV knowledge of respondents. Cronbach alphas were computed on measures with participants in our sample and were reported when relevant. The section on HIV Knowledge assessed participants' knowledge of HIV/AIDS. This measure consisted of six true or false items. Responses were scored "0" for an incorrect response and "1" for a correct one. A sample item is "Only people who look sick can spread the HIV virus."

The final section, Behavior & Relationships, included items assessing drug use and sexual behavior over the past 30 days. *Past 30 Day Drug Use* was assessed by ten items in which participants were asked about use of several specific drugs in the past 30 days. These drugs included cigarettes, other tobacco products, alcohol, marijuana, cocaine, methamphetamine, and other illegal drugs. *Sexual Experiences* were assessed with seven items asking about the respondent's sexual behavior and whether condoms were used. An example item was, "Have you ever had sex (vaginal, oral, or anal)?" Participants responded to

dichotomous variables, including either “yes/no” or “protected/unprotected.” *Sexual Behaviors* were assessed with seven items asking about sexual behaviors both in the past three months and lifetime. An example item was, “In the past 3 months, have you had sex with any men/women?” Participants responded to dichotomous variables of either “yes” or “no.”

The Raise 5 Program Survey was also given to participants in the evidence based interventions. It included a variety of measures assessing constructs such as condom attitudes, condom negotiation efficacy, condom use efficacy, HIV testing attitudes, and HIV conspiracy beliefs. These constructs have been linked to HIV risk and protection (Bogart & Thorburn, 2005; Marks et al., 2006; Weller & Davis, 2002).

Condom Use Attitudes were measured by a seven item scale from the SISTA pre-test/post-test survey (DiClemente & Wingood, 1995). Items assessed attitudes towards condoms. An example item is, “Sex with condoms does not feel natural.” Participants respond on a 4-point Likert scale, with response options ranging from “1” for “strongly disagree” to “4” for “strongly agree”. Lower scores indicate more favorable attitudes towards condoms. The Cronbach reliability coefficient was .86 in a previous study with African American females (Nguyen et al., 2010). Across the three data collection points, the Cronbach’s alphas for this measure ranged from .69 to .82 with this sample.

Condom Negotiation Efficacy was measured with a seven item scale from the SISTA pre-test/post-test survey (DiClemente & Wingood, 1995). Items were designed to assess efficacy for negotiating condom use with a primary partner. A sample item includes, “Can you insist on condom use if your main partner does not want to use one?” Participants responded on a 4-point Likert scale, with response options ranging from “1” for “definitely no” to “4” for “definitely yes”. Higher scores indicate higher levels of condom negotiation efficacy. The scale had a

Cronbach reliability coefficient of .85 in a previous study with African American women (Nguyen et al., 2010). With this sample, the Cronbach's alphas ranged from .75 to .79.

Condom Use Efficacy was measured with nine items from the SISTA pre-test/post-test survey (DiClemente & Wingood, 1995). Items assessed participants' efficacy for properly using the male condom. A sample item includes "How confident are you that you could put a condom on a hard penis?" Items were adapted for male participants. Response options ranged from "1" for "not confident" to "3" for "very confident". Higher scores indicate higher condom use efficacy. The Cronbach reliability coefficient for the condom use efficacy scale was .92 for African Americans in a previous study (Nguyen et al., 2010). Across three data collection points, the Cronbach's alpha for this measure ranged from .88 to .90 within this sample.

HIV Testing Attitudes were measured with the HIV-Antibody Testing Attitude Scale (HTAS) developed by Boshamer and Bruce (1999). This scale assesses general attitudes towards HIV testing. The scale includes items such as "My friends would look down on me if I were tested for HIV." The items are on a 7 point Likert scale with responses ranging from 1 for "strongly disagree" and 7 for "strongly agree". Higher scores indicate more negative attitudes towards HIV testing. This scale has been found to have good validity and reliability with a Cronbach's alpha of .88 (Boshamer & Bruce, 1999). Across the data collection points, the Cronbach's alphas ranged from .79 to .84.

HIV/AIDS Conspiracy Beliefs were measured with the HIV Conspiracy Theory scale developed by Bogart and Thorburn (2005). An example item is "AIDS was created by the government to control the African American population." Responses are on a seven point scale ranging from 1 for "strongly disagree" to 7 for "strongly agree." Higher scores indicate stronger belief in HIV conspiracy theories. This scale has demonstrated good validity and reliability;

Bogart and Thorburn (2005) reported a Cronbach's alpha of .85. The Cronbach's alphas for this measure ranged from .85 to .88 in this study.

Strategies II and IV: Peer education events and social marketing campaign. The National College Health Assessment (see Appendix H) was developed by an interdisciplinary team of college health professionals of the American College Health Association (ACHA). This 66 item online instrument collects data about college students' health habits, behaviors, and perceptions. Topics include health education, personal safety, violence, relationship issues, substance use, and sexual health and contraception. The assessment also includes a section on demographic characteristics, such as age, gender, sexual orientation, year in school, height, and weight. Measures on the NCHA II relevant to the evaluation of the Raise 5 Project will be discussed. These measures include sex and substance use behaviors and attitudes.

The first section is entitled Health, Health Education, and Safety. It includes an item assessing the respondent's general health. This is followed with two items. The first assesses whether the respondent had received information on certain health topics from the university. The next item assesses if the respondent is interested in receiving information on the same topics. The list of topics include: alcohol and drug use, depression/anxiety, and STIs. The next three items assess whether the respondent has: 1) engaged in risky behaviors, 2) been physically or sexually assaulted or 3) was in an abusive relationship. All three items assess behavior in the last 12 months. The section concluded with an item assessing how safe the respondent felt on campus.

The second section, Alcohol, Tobacco, and Drugs, began with two items assessing 30 day drug use. The first item assessed on how many days the respondent used certain drugs within the

last 30 days. The second item assessed how many days the respondent felt the typical student used certain drugs during the last 30 days. The drugs included cigarettes, alcohol, marijuana, cocaine, methamphetamines and others. The next three items assessed the last time the respondent “partied”: 1) how many alcohol drinks did they have, 2) how many hours did they drink, and 3) how many drinks did they feel a typical student would have. This was followed by an item assessing how many times the respondent had five or more drinks in the last two weeks. There was also an item assessing whether participants had driven an automobile after drinking. The section concluded with three items assessing behavior in the last 12 months: 1) how often did the participant engage in safe drinking behavior, 2) engage in risky behavior while drinking, and 3) if they used any prescription drugs?

The next section is on Sex Behavior and Contraception. It begins with two items assessing how many sexual partners the respondent had and the sexual orientation of one’s partners. There are also two items assessing the types of sexual activities the respondent had engaged in and if condoms were used. There were also items assessing whether respondents had used birth control the last time they had vaginal intercourse and the types of birth control were used. The section concluded with items assessing whether respondents (or a partner) had become pregnant or used emergency contraception (i.e., the “morning after” pill).

The final section was entitled Impediments to Academic Performance. It assesses whether a variety of factors have affected the respondent’s academic performance within the past twelve months. Factors included alcohol use, assault, depression, drug use, and STIs.

Procedure

Strategy I: Evidence based interventions. This study was first approved by the university's Institutional Review Board. Data were collected at a university in the southeastern U.S. Data were collected by trained researchers and research assistants. Generally, a female member of the evaluation staff collected data for SISTA, a male collected data for Nia, and either gender collected data for Safe in the City. Participants were enrolled in the study upon providing verbal consent. During the first session of SISTA and Nia, participants signed and completed informed consent forms. Safe in the City participants also completed these forms during their single session.

During all data collection sessions, students were seated far enough apart to ensure privacy. Following protocol, a survey prompt was read aloud that included information about how to complete the survey and the students were reminded that their participation was voluntary and their responses were anonymous. Intervention participants in Nia and SISTA completed pre, post, and three month follow-up surveys. Participants in Safe in the City only completed post-test and follow-up surveys. Participants were provided \$10 for completing the pre-test survey, and \$20 for post-test and follow-up surveys.

Data Analysis Plan

Strategy I: Evidence based interventions. Data were analyzed using SPSS 22. Preliminary descriptive analyses were conducted to screen data for outliers and violations of the assumptions of ANOVA including normality, homogeneity of variance, and sphericity. A correlational matrix was computed to determine associations among study variables. I also examined demographic differences among participants in the three interventions to determine if these groups differed demographically since the recruitment strategy was not random. A series of t-test or chi-square tests (depending on categorical or continuous outcome variable) were

computed to determine if intervention females (and intervention males) differed from comparison females (and males) on demographic variables such as relationship status, year in college, and age. If there were demographic differences, they were statistically controlled for in multivariate analyses comparing groups.

The first outcome evaluation question examined if the Raise 5 Project had adequate retention rates for the evidence based interventions? This was assessed by performing a frequency analysis to determine the percentage of participants that completed post-test and follow-up data collection. A variety of analyses were conducted to answer the four outcome evaluation questions: 2) Did participants across all evidence based interventions demonstrate reduced HIV and substance use risk? 3) Did women in SISTA have reduced HIV and substance use risk compared to women in Safe in the City? 4) Did men in Nia have more reduced HIV and substance use risk compared to men in Safe in the City? 5) Did women in Enhanced SISTA have reduced HIV and substance risk compared to women in standard SISTA?

These questions involved an assessment of a variety of continuous and nominal outcome variables, and as such both univariate and multivariate analyses were performed. To examine within group differences (e.g., paired categorical outcomes), a series of McNemar's tests were conducted. These analyses assessed whether there were differences among participants from pre-test-to-post-test, and pre-test -to-follow-up on unprotected sex for participants in SISTA and Nia and from post-test to follow-up for participants in Safe in the City. In order to examine group differences (based on intervention type) on categorical outcomes, a series of chi-square tests were performed. For example, a chi-square was computed to determine if there were differences among the intervention and comparison groups in receiving an HIV test.

A series of mixed between –within subject ANOVAs were originally performed to assess if there were main effects of time and intervention type as well as interactions on continuous outcomes variables (e.g., condom attitudes, negotiation, and efficacy). However, pre-test data were not collected for participants in Safe in the City. As such, a series of repeated measures ANOVAs were conducted to assess within subjects differences. The first series of analyses assessed changes among SISTA and Nia participants. The second series of analyses examined change within Safe in the City participants. Also, a series of ANCOVAs were conducted to assess between subject differences between participants in SISTA/Nia and Safe in the City. If demographic variables such as relationship status and age were found to relate to outcome variables, they were statistically controlled for.

Strategies II and IV: Peer education events and social marketing campaign.

Descriptive statistics were computed for outcome measures including “The last time you “partied”/socialized how many drinks of alcohol did you have?”, “The last time you “partied”/socialized over how many hours did you drink alcohol?” and “How many drinks of alcohol do you think the typical student at your school had the last time he/she “partied”/socialized?” Other outcomes include the number of sexual partners in the last 12 months, whether participants engaged in unprotected sex after drinking, 30 day drug use, 30 day sexual activity, and whether 30 day sexual activity was protected or unprotected. The mean number of drinks, hours spent drinking, and number of sexual partners were assessed. Also, frequency analyses were performed to assess what percentage of students reported having unprotected sex after drinking alcohol, 30 day drug use, 30 sexual activity, and whether 30 day sexual activity was protected or unprotected. A series of ANCOVAs were performed to assess between subjects differences in respondents from 2010 and 2014.

Results

There are two main components of this evaluation: 1) a process evaluation which summarizes how the various strategies of the Raise 5 Project were implemented and 2) an outcome evaluation which examined if the project achieved its desired effects. Twelve questions were developed to guide the evaluation. The first six questions related specifically to the process evaluation, while the final six were developed for the outcome evaluation.

Findings from Process Evaluation

The first three process evaluation questions assessed the implementation of the evidence based interventions. The first sought to determine if the interventions were delivered with fidelity. The second examined if intervention facilitators experienced any challenges while delivering the interventions. The third evaluation question assessed the views of the students who participated in the evidence based interventions. The next two process evaluation questions examined if the peer education and awareness events reached the target population and what their responses were to these programs. The final process evaluation question sought to determine if the free HIV testing events reached and were utilized by the target population.

Question 1: Were the Evidence Based Interventions Delivered With Fidelity?

According to Nigg, Allegrante, and Ory (2002) fidelity can be defined as implementing an in the way it was planned. This includes two primary aspects, the intervention's core elements and its internal logic. Core elements are the aspects of an evidence based intervention that represent its theory and internal logic. In addition, the core elements produce the intervention's main effects on behavior change. An intervention's internal logic is the explanation of the relationships between intervention activities, the factors from behavioral

theory that impact behavior (behavioral determinants), and the intended outcomes of the intervention. Core elements are often based on components of the behavioral theory used to design the intervention. As such, core elements are very important and must be implemented with fidelity to increase the likelihood that the program will produce its intended effects. While core elements cannot be altered, certain aspects of interventions can be modified to fit the needs of a particular situation.

SISTA core elements. According to the SISTA Implementation Manual (CDC, 2008), there are seven core elements:

- 1) Convene small-group sessions to discuss session objectives, model skill development, role-play women's skill acquisition, and address the challenges and joys of being an African American woman.
- 2) Use skilled African American female facilitators to implement SISTA group sessions.
- 3) Use culturally and gender appropriate materials to acknowledge pride, and enhance self-worth with regard to being an African American woman (e.g., using poetry by African American women).
- 4) Teach women to communicate both verbally and non-verbally to show they care for their partner and need to protect themselves (e.g., negotiation skills, assertive communication skills).
- 5) Instruct women on how to use condoms effectively and consistently (e.g., negotiation skills, assertive communication skills).
- 6) Discuss culture and gender-related issues and barriers using condoms (e.g., provide information on African American women's risk of HIV infection).

- 7) Emphasize the importance of a partner's involvement in safer sex (e.g., enhance partner norms supportive of condom use).

Nia core elements. Nia is a video based intervention and several of the core elements include showing videos and movie clips. While videos were included in the intervention materials, other videos can be used if they are more recent and appropriate for the target population. The *Nia Facilitator's Guide* specifies five core elements:

- 1) Conduct small group sessions with men who have sex with women that are led by culturally competent male and female co-facilitators who present HIV information using videos and movie clips relevant to African American men, motivate risk-reduction, build skills for handling common risk situations, and challenge negative attitudes towards women through group rules that disallow adversarial language against women.
- 2) Correct misperceptions and misinformation regarding HIV by using gender and culturally appropriate videos and interactive exercises, especially by providing personal feedback on HIV knowledge, showing and leading discussion of HIV educational videos, and conducting the Myths and Facts and HIV Risk Continuum activities.
- 3) Induce and enhance motivation to reduce risks for HIV by having men identify themselves and their behavior with the HIV epidemic through providing personal feedback on sex behaviors and condom attitudes, showing and leading discussion of videos featuring men affected by HIV that participants can identify with, and eliciting and exploring personal risky sexual situations.
- 4) Build skills for identifying and managing sexual risk situations by guiding the practice of recognizing risky situations through trigger-identification and developing safer sex decision-making skills using movie clips.

- 5) Enhance motivation and building behavioral skills for condom use or safer sex by exploring attitudes toward and pros/cons for condom use, identifying safer sex alternatives, building behavioral skills for correctly using condoms and communicating sexual decisions regarding condom use, and guiding practice of condom use and safer sex decisions using movie clips.

In order to assess the fidelity of intervention delivery, two members of the evaluation team performed systematic observations of Nia sessions. SISTA sessions were observed by a senior SISTA facilitator. See Appendix I for an example of an observational report.

Graduate and undergraduate students were trained to facilitate SISTA and Nia by CDC certified trainers. Training for SISTA was for four days, while Nia training was for three days. As such, facilitators were trained to deliver the interventions with a great deal of fidelity. Observations indicated that facilitators of both interventions adhered to the core elements. SISTA was always delivered by two African American female facilitators. Nia was always facilitated by an African American male and female. In addition, the interventions were always delivered with small groups no larger than 12 participants. All activities described in the *SISTA Implementation Manual* and the *Nia Facilitator's Guide* were performed and facilitators lead discussions of HIV, condom use, and negotiating safe sex. Culturally relevant intervention materials were utilized for both interventions. For example, African American poetry was used in SISTA sessions. Some examples of the poems used include "Ego Tripping" by Nikki Giovanni and "Phenomenal Woman" by Maya Angelou. Movie clips featuring African American actors (e.g., *Jason's Lyric* and *Baby Boy*) were used heavily during Nia sessions. Some minor adaptations were made to Nia sessions, as facilitators replaced the intervention's original video clips with clips from more recent films.

Facilitators faced a few challenges in maintaining the intervention's fidelity. The most common change to SISTA sessions was the time length for session activities. SISTA's training materials specify the amount of time for each activity during a session. Circumstances did not always permit these time guidelines to be followed. For example, if participants arrived to sessions late, certain activities had to be condensed or delayed. More salient changes were made to Nia's delivery. The training materials specified that facilitators should hold an initial intake session, in which they complete a Pre-Intervention Assessment Survey. This survey is used to create Personal Feedback Report (PFR) forms which are passed out during 1 Nia sessions. The purpose of these forms is to motivate participants to change their risky behaviors by: 1) helping them compare what they currently do to what they want to do and 2) reinforcing existing safer behaviors that participants want to maintain.

The first PFR allows Nia participants to compare their answers to accurate HIV information, the second demonstrates risky sexual behaviors, and the third addresses their attitudes towards condom use. The Pre-Intervention Assessment and PFR forms support some of the core elements including the second (correcting misperceptions and misinformation regarding HIV) and the third (inducing and enhancing motivation to reduce risks for HIV) by reminding participants how they responded to questions on the Pre-Intervention Assessment Survey. While these forms were important, the National Minority SA/HIV Prevention Initiative Adult Questionnaire (CSAP, 2009) and a variety of other local measures had to be administered as part of the evaluation. As such, the Pre-Intervention Assessment was not administered to prevent survey fatigue. Despite these challenges, facilitators were able to deliver SISTA and Nia in accordance with the core elements of each intervention.

Question 2: Did Facilitators Experience any Complications or Challenges While Delivering Interventions?

To answer this evaluation question, semi-structured interviews were conducted with four intervention facilitators (two from SISTA and two from Nia) (See Appendix J for transcribed interviews). Facilitators were asked the following four questions:

- 1) Do you feel you were able to facilitate with fidelity?
- 2) Were there any challenges or complications you experienced? If so, how did you deal with them?
- 3) How do you think participants benefitted from the intervention?
- 4) Do you have any final thoughts about your time as a facilitator?

Two SISTA facilitators (out of ten) were interviewed. They both suggested that managing group dynamics was the most difficult aspect of facilitating. In particular, the facilitators had to manage the different personalities within groups. The facilitators suggested that it was challenging to manage the more outgoing participants who dominated the group's discussions. Facilitators did not wish to make any participant feel "shut down or shut out of the conversation." As such, a strategy they used was to remind participants that there was much more material to cover and they would have to move the discussion along.

Facilitators also noted that it was also challenging to get more introverted participants to speak up and get involved. The strategy to address quiet or unengaged participants was to go around the room and have everyone to share their thoughts. One facilitator reported that she later learned that some of these participants were sexual minorities and did not identify as heterosexual. She also noted that since SISTA was designed for women who have sex with men

these women may not have been as engaged because they did not find the information to be relevant for them.

Further challenges were related to logistics, such as getting participants to show up on time. Having late arrivers would affect the course of the entire session, as starting later made the session end later. This could be a source of frustration for both participants and facilitators.

Nia was delivered by four facilitators (two men and two women). Two facilitators (one male and one female) were interviewed about their experiences facilitating the intervention. The primary male facilitator suggested that scheduling was a major challenge. Project staff attempted to schedule Nia sessions at the most convenient times for students. Sessions were scheduled to not interfere with holidays, breaks, or the weeks of final exams. However, other events on campus (e.g., basketball games) could affect attendance at Nia sessions. Inclement weather was another issue which impacted attendance of a few sessions. The weather issue could not often be anticipated and in a few cases sessions had to be cancelled. Another complication mentioned by the male facilitator was that the intervention materials provided in the training were somewhat dated. He noted that many participants did not feel that the movie clips were personally relevant for them. In order to address this, staff had to identify more contemporary movie clips to show participants.

The primary female Nia facilitator was also interviewed regarding her experiences. She noted that participants were generally engaged and eager for the group discussion. However, there were a small number of participants who were not engaged in the discussion and seemed to only want to get the incentive. She also mentioned that recruiting participants was a challenge. The average size of a Nia cohort ($M = 7.72$), was smaller than SISTA ($M = 9.5$). The facilitator also noted that in addition to having challenges in recruiting participants, some dropped out of

the program. She noted that she and her co-facilitator often reached out to participants who missed sessions through phone call or text message to address this issue. However, these attempts often had mixed results. As such, she described sessions in which she facilitated groups as small as three participants. She felt this was especially challenging because it did not lead to viable discussions.

Question 3: What Were the Participants' Views of the Evidence Based Interventions?

Participant feedback was provided via participant feedback forms completed at the end of each session (see form in Appendix K). Participants rated the activities in each session, the overall quality of the session, and their perception of the quality of the facilitators. Participants also provided information about how they felt the session could be improved and any changes they made as a result of the previous session. Scores ranged from “1” for poor to “10” for excellent. Data were analyzed from a random sample of 50 surveys which came from 10 participants who were randomly selected. These participant surveys from all five sessions were included in analyses.

SISTA participant feedback. Participants frequently rated the performance of facilitators and their overall experience in SISTA as excellent. Participants responded very favorably to the intervention facilitators with scores ranging from 9.80 to 9.95. In addition, participants responded favorably to each SISTA sessions, with scores ranging from 9.65 to 9.90. Session 5 had the lowest mean score, with many participants noting that the final session was less fun and exciting than the others. This is likely due to most of this session being devoted to data collection. The final feedback form asked participants to rate SISTA as a whole and the average score was 9.94. Refer to Tables 2 and 3 below for the average ratings of the sessions and the overall performance of SISTA facilitators.

Table 2.

Participant Ratings of SISTA Facilitators

| Session 1 | | Session 2 | | Session 3 | | Session 4 | | Session 5 | |
|-----------|-----|-----------|-----|-----------|-----|-----------|-----|-----------|-----|
| Mean | SD | Mean | SD | Mean | SD | Mean | SD | Mean | SD |
| 9.85 | .36 | 9.80 | .52 | 9.95 | .22 | 9.90 | .44 | 9.80 | .41 |

Table 3.

Participant Ratings of SISTA Sessions

| Session 1 | | Session 2 | | Session 3 | | Session 4 | | Session 5 | |
|-----------|-----|-----------|-----|-----------|-----|-----------|-----|-----------|-----|
| Mean | SD | Mean | SD | Mean | SD | Mean | SD | Mean | SD |
| 9.70 | .57 | 9.80 | .41 | 9.85 | .48 | 9.90 | .30 | 9.65 | .58 |

Participants commented on benefiting from SISTA in a variety of ways. For example, one participant noted that she “tried to incorporate what I’ve learned into my life. It helps a lot and I never thought of being this in control of my life.” Another suggested “these session have helped me value myself more and to be more understanding of my worth. I will continue to practice safe sex from here on out.” Many participants noted they felt more comfortable talking about condoms with their partners. Several mentioned becoming proactive about condom use, by taking the step of buying condoms for themselves. Others mentioned developing more positive attitudes towards condoms and trying to spread this knowledge on to their friends, suggesting that “they aren’t something to be ashamed of.” Another participant noted that “I

thoroughly enjoyed SISTA! I will definitely recommend this to program! The facilitators did an awesome job! I wish this program was longer!”

Nia participant feedback. Participant feedback data were collected from one cohort of five participants. Participants frequently rated the performance of facilitators and their overall experience in Nia as excellent. The intervention received very positive feedback for the duration of the project. Participants responded very favorably to the intervention facilitators with scores ranging from 9.60 to 9.80. In addition, participants responded favorably to all Nia sessions, with scores ranging from 9.00 to 9.80. The final feedback form asked participants to rate Nia as a whole and the average score was 9.55. Refer to Tables 4 and 5 for the average ratings of the sessions and the overall performance of Nia facilitators.

Table 4.

Participant Ratings of Nia Facilitators

| Session 1 | | Session 2 | | Session 3 | | Session 4 | |
|-----------|-----|-----------|-----|-----------|-----|-----------|-----|
| Mean | SD | Mean | SD | Mean | SD | Mean | SD |
| 9.60 | .54 | 9.80 | .44 | 9.60 | .89 | 9.80 | .44 |

Table 5.

Participant Ratings of Nia Sessions

| Session 1 | | Session 2 | | Session 3 | | Session 4 | |
|-----------|-----|-----------|-----|-----------|------|-----------|-----|
| Mean | SD | Mean | SD | Mean | SD | Mean | SD |
| 9.80 | .44 | 9.60 | .54 | 9.00 | 1.22 | 9.80 | .44 |

Participants also noted the variety of positive ways in which they incorporated what they learned in the program. For example, some participants noted they stopped drinking as much. One participant noted that he now planned on “thinking ahead when partying.” Another mentioned that he now “took responsible friends with him to parties instead of going alone.” Another participant noted that he now tried “not to put himself into risky situations where risky activities may occur.” Some of the comments provided by participants following the end of the intervention include, “Wonderful program!”, “Helpful information! No improvements needed!” and “Great group leaders!”

Many participants asked if more sessions could be added or if the session could be lengthened. Most participants felt that the sessions did not need improvement beyond updating intervention materials. In particular, participants called for updated videos to replace those developed for the intervention, which was developed during the mid-1990’s. These findings suggest that SISTA and Nia were both positively regarded by participants.

Question 4: Did the Target Population (African American Students) Attend the Peer Education and Awareness Events?

In order to answer this evaluation question, monitoring was done to assess whether the target population actually attended events. Eight edutainment events were hosted by the Raise 5 Project, often one event a semester. Data were collected at five of these events. The Raise 5 Project's edutainment series, *Viewpoint: The Black Perspective* began on February 1, 2011 with *Sex, Drugs, You and Your Boo*. This event was attended by 87 individuals. The audience was 80.5% African American (n = 70), 17.2% White (n = 15), 1.1% Asian (n = 1), and 1.1% Latino (n = 1). The next event, *Sweet Temptations*, was held on September 7, 2011 and was attended by 53 students. The audience was 66% African American (n = 35), 13% Latino (n = 7), 11% White (n = 6), 6% Asian (n = 3), and 4% other (n = 2). One hundred forty-five students attended the third event, *Evening at the Improv*, which was held on October 26, 2011. The audience was 64% African American (n = 93), 14% White (n = 20), 10% Latino (n = 15), 7% other (n = 10), and 5% Asian (n = 7). One hundred and eight students attended a second *Evening at the Improv* event which was held on October 9, 2012. The audience was 89% African American (n = 96), 9% White (n = 10), and 2% Asian (n = 2). Eighty-eight students attended the project's final event, *Scandal*, which was held on February 11, 2014. The audience was 81% African American (n = 71), 9% Asian (n = 8), 9% White (n = 8), and 1% Latino (n = 1). These data indicate that the Raise 5 Project was largely able to implement its edutainment series for its target population.

Question 5: What were Students' Responses to the Education and Awareness Events?

Specific feedback from the first three events will be discussed, as these events were particularly influential in shaping the later programs. Framed as a talk show, the show was hosted by VCU students including graduate students who worked on the Raise 5 project along with undergraduate research assistants and Black campus groups and organizations. A

participant feedback survey was provided to students before the events began. After the events concluded, audience members were encouraged to complete the survey and return to members of the evaluation team. These forms included items which assessed the respondent's knowledge of the Raise 5 Project, their feelings about the event they had just attended, and the best methods to contact them for future events. Three items from the feedback form will be summarized: 1) if participants felt the information was valuable, 2) if they gained new knowledge of HIV/substance /abuse, and 3) if they planned to incorporate this information into their lifestyle.

Data were analyzed from 100 surveys that were randomly selected (30 from the first event, 20 from the second event, and 50 from the third event). Refer to Table 6 for descriptive information on these items. The first three edutainment events hosted by the Raise 5 Project were very well received. In response to the question assessing whether the information presented was valuable, the average score ranged from 4.22 to 4.82. There were also high scores (ranging from 4.50 to 4.66) in response to whether or not respondents gained new HIV and substance abuse knowledge. The audience also reported planning to incorporate this new knowledge into their lifestyle, with scores ranging from 4.33 to 4.62.

Table 6.

Student Reactions to First Three Edutainment Events

| Item | Event | | | | | |
|---|---------------------------------|-----|-------------------|------|-----------------------|-----|
| | Sex, Drugs, You and Your Boo | | Sweet Temptations | | Evening at the Improv | |
| | Mean | SD | Mean | SD | Mean | SD |
| 1) Information was valuable. | 4.37 | .51 | 4.22 | 1.09 | 4.82 | .39 |
| 2) Gained new knowledge. | 4.50 | .53 | 4.66 | 1.00 | 4.64 | .70 |
| 3) Intend to incorporate into my lifestyle. | 4.62 | .51 | 4.33 | 1.00 | 4.58 | .71 |

The first program, *Sex Drugs, You and Your Boo*, began with an “icebreaker” which assessed and sought to increase the audience’s knowledge of HIV. It also included a panel discussion with individuals knowledgeable about HIV. One of the most well received aspects of the program was the testimony from an HIV positive woman. This was particularly impactful as many students had not met or spoken with a person living with HIV. Afterwards, student cohosts facilitated panel discussions and a question and answer period. This event also included a live commercial skit, which was very well received by the audience. In fact, one student commented that the skit was a great way of demonstrating the need to increase HIV awareness.

The second event, *Sweet Temptations*, incorporated changes based on the feedback from students who attended the previous event. In addition, there were other changes in the format and content based on feedback provided by focus groups, student interviews, and the project's Advisory Council. As such, this event aimed to provide the audience a greater opportunity to participate. Two graduate students hosted the event, which largely consisted of assessing the audience's HIV and substance abuse knowledge through a series of questions. Upon entry into the event's facility, audience members were given "clickers" provided by Dr. Linda Hancock and the Wellness Resource Center. During the event, the audience used the clickers to answer questions posed by the two cohosts. Those who answered the questions the fastest were provided a prize. This event also consisted of a presentation by Ms. Susan Tellier of the Fan Free Clinic, who spoke on drug use and HIV risk. The audience's responses in the feedback survey were very positive. For example, one respondent noted that "I really liked the clicker questions and seeing the stats after. I also really liked how real they were with us." The cohosts were also noted for their professionalism.

The third event, *Evening at the Improv*, was the first collaboration with student organizations, (e.g., Delta Sigma Theta, Inc. and the VCU NAACP). Due to the positive response of the skit in the first event, *Evening at the Improv* was an entirely skit based event. The students portrayed four different skits which reflected real life scenarios of people dealing with HIV (e.g., going to the clinic or testing positive and having to tell one's partner). The ideas for the four skits were developed by project staff and students were encouraged to form groups and volunteer to participate. Once the groups were identified, students were provided with a skit idea. At the event, the four groups performed their skits. In between groups, audience members were asked to volunteer to perform in improvisational situations as well. For example,

participants were asked to role play being different drugs (e.g., marijuana, alcohol, etc.) and act out the negative implications of their drug. After the four groups performed, the audience voted for the best performance and members of that group received prizes. The event was one of the project's most attended and most well received. For example, one audience member noted, "This was my first time attending an improv event. I really enjoyed it, it was different. I think messages are taken better when we actually see things in action, versus just listening to someone teach or preach it to you." Another student reported "I liked how the event showed other students who were my age and who had an interest in HIV. It showed me that we are not too young to care. The skits were very informative and entertaining."

These findings suggest that the Raise 5 Project's peer education events were very well received. Not only were the events interactive and entertaining, they provided the students with new information that they felt was valuable and that they planned on incorporating into their lifestyle.

Question 6: Did the Target Population (African American Students) Attend Testing Events?

This question was addressed by reviewing program records and surveys collected from students who received testing. This information was used to assess the number of individuals who were tested and their stated reasons for getting the HIV test. In collaboration with the Fan Free Clinic, the Raise 5 Project began offering free HIV testing services in December 2011. On this date, 98 students were tested for HIV. Fifty two percent ($n = 51$) were African American and 48% ($n = 26$) were of another race or ethnicity. In 2012, the Raise 5 Project held six testing events. A total of 350 students were tested in 2012, with an average number of 58.33 students

tested at each event; 55% ($n = 191$) of these students were African American and 45% percent ($n = 159$) were of another racial or ethnic group.

Five testing events were held in 2013, with 289 students being tested in total. An average number of 57.80 students were tested at each event in 2013. Fifty four percent ($n = 156$) of these students were African American and 46% ($n = 133$) were from another racial group. Another five testing events were held in 2014 and 213 students were tested in total. Last, one testing event was held in 2015 and 31 students were tested in total.

In total, 981 students received an HIV test from 2011 to 2015. The average number of students tested at each event was 54.5. African Americans made up the majority of those who were tested (55%). In total, 539 ($M = 29.94$) African American students were tested. Other ethnic/racial groups made up the other 45%, with 442 ($M = 24.55$) students tested.

Prior to the HIV testing, a brief risk assessment survey was administered. Participants were asked to indicate the reasons for getting the testing. A random sample of surveys from 45 students was selected. Students could select all of the risk factors that applied as their reason for testing. Forty two percent ($n = 19$) reported testing because they had multiple sexual partners, 42% reported testing because they had sex with someone whose HIV status they did not know or were not sure about, and 27% ($n = 12$) reported knowing or suspecting that their partner was having sex with other people. Also, 24% ($n = 11$) reported having sex with an anonymous partner.

Table 7.

Number and Race/Ethnicity of Students Tested

| Year | African American | | Other | | Total |
|-------|------------------|---------|-------------|---------|------------|
| | Number | Percent | Number | Percent | |
| 2011 | 51 | 52% | 47 | 47 | 98 |
| 2012 | 191 | 55% | 159 | 45 | 350 |
| 2013 | 156 | 54% | 133 | 46 | 289 |
| 2014 | 128 | 60% | 85 | 40 | 213 |
| 2015 | 13 | 42% | 18 | 58% | 31 |
| Total | 539 | 55% | 442 | 45% | 981 |
| | (M = 29.94) | | (M = 24.55) | | (M = 54.5) |

Summary of Findings from Process Evaluation

The first process evaluation question assessed if the evidence based interventions were delivered with fidelity. Systematic observations indicated that facilitators of SISTA and Nia adhered to the core elements of both interventions. Both interventions were delivered with the appropriate facilitators: two African American women for SISTA and an African American man and woman for Nia. The interventions were always delivered in a small group format with no more than 12 participants. Activities were delivered the way they were described in the *SISTA Implementation Manual* and the *Nia Facilitator's Guide*. In addition, project staff made use of culturally relevant intervention materials for both interventions (e.g., African American poetry and videos).

The second evaluation question examined if facilitators experienced any complications or challenges while delivering interventions. Semi-structured interviews with four facilitators (two from SISTA and two from Nia) determined that a few challenges emerged during the implementation of these interventions. Both SISTA facilitators mentioned that managing the different personality types within groups was sometimes challenging. They reined in the more talkative participants by reminding them they had much more material to cover. They encouraged the more reserved participants to participate by going around the room and asking everyone to share their thoughts. Additional challenges were related to logistics, such as getting participants to show up on time.

The Nia facilitators also mentioned a few complications. The primary male facilitator suggested that scheduling was a challenge. Some participants chose to attend other events on campus (e.g., basketball games) rather than Nia sessions. Inclement weather was another issue which impacted attendance of sessions. Having outdated materials was another challenge this facilitator mentioned. The primary female Nia facilitator mentioned recruitment and participant drop out as being challenges. Having smaller groups than anticipated made it more difficult to deliver the intervention.

The third question sought to determine the participants' views of the evidence based interventions. This was assessed through participant feedback forms which were completed after every session. SISTA and Nia participants rated the performance of facilitators, each session, and their overall experience as excellent. SISTA participants mentioned a variety of benefits, including an increased self-worth. They also became more knowledgeable about condom use and more comfortable about discussing condoms. Many participants reported enjoying their

experience and recommending the program to their friends. Nia participants reported changes in behavior, such as reduced drinking and thinking more about the consequences of their actions.

The fourth evaluation questions examined if the target population attended the peer education and awareness events. Data from participants was examined to assess whether the target population was attending the edutainment events. Data were available for five of these events. African American students made up from 64% to 89% of the audience at these five events. These data indicate that the Raise 5 Project was largely able to implement its edutainment series for its target population.

The fifth question assessed students' responses to the education and awareness events. Students were encouraged to complete a participant feedback survey after each event. The first three edutainment events were very well received. In response to the question assessing whether the information presented was valuable, the average score ranged from 4.22 to 4.82, with "5" being the highest possible score. There were also high scores (ranging from 4.50 to 4.66) in response to whether respondents gained new HIV and substance abuse knowledge. The audience also reported planning to incorporate this new knowledge into their lifestyle, with scores ranging from 4.33 to 4.62. These findings suggest that students who attended the Raise 5 Project's edutainment events learned new information, found it to be valuable, and planned on incorporating it into their lifestyle.

The final process evaluation question assessed if the target population attended testing events. Data collected by the Fan Free Clinic were utilized to answer this question. Data indicate that across four years of providing free HIV tests, African Americans made up the

majority of students who were tested. The percentage of African American testers for each year ranged from 52% to 60%. In total, 526 (56%) African American students were tested.

Findings from Outcome Evaluation

The first outcome evaluation question assessed the retention rate for participants in the evidence based interventions. The second examined if intervention participants demonstrated reduced HIV and substance use risk. In order to answer this question, a series of repeated measures ANOVAs and McNemar tests were performed. The following two questions compared the outcomes of intervention participants to those in the comparison group. In addition, a question assessed the outcomes of participants in standard SISTA compared to those in the enhanced version. The final outcome evaluation question assesses if the African American student population demonstrated reduced HIV and substance use risk over the period of the project. A series of ANCOVAs and chi-square tests were conducted in order to answer the final four outcome evaluation questions.

Preliminary analyses for demographic comparison of groups. A series of independent samples t-tests and chi-square tests were conducted to assess if there were any significant differences between participants in SISTA and Nia compared to those in Safe in the City on demographic variables including age, education level, and relationship status. Refer to Tables 8 and 9 for descriptive information on demographic variables. Analyses of demographic variables comparing women in SISTA to those in Safe in the City will be discussed next.

Pre-test data on Safe in the City were not collected, so demographic data at post-test was assessed. At post-test, women in SISTA ($M = 19.94$, $SD = 1.51$) were significantly younger than those in Safe in the City ($M = 20.38$, $SD = 1.41$), $t(212) = -2.077$, $p = .039$. At post-test, women

in Safe in the City ($M = 14.09$, $SD = 1.77$) had significantly higher education levels than those in SISTA ($M = 13.53$, $SD = 1.49$), $t(212) = -2.464$, $p = .015$. At post-test, a chi-square test found a significant relationship between condition (SISTA and Safe in the City) and relationship status, $X^2(1, N = 188) = 4.020$, $p = .045$. As such, Safe in the City participants were more likely to be informally married or living with a permanent partner. Due to the significant differences in age, education, and relationship status at post-test, these three variables were controlled for in subsequent analyses comparing SISTA and Safe in the City.

Preliminary analyses were also conducted to assess differences between Nia and Safe in the City. At post-test, there was no significant age difference for men in Nia ($M = 20.66$, $SD = 1.78$) and Safe in the City ($M = 21.50$, $SD = 2.48$), $t(107) = -1.88$, $p = .121$. There were no significant post-test differences in education level between men in Nia ($M = 13.76$, $SD = 1.56$) and Safe in the City ($M = 14.00$, $SD = 2.78$), $t(109) = -.549$, $p = .584$. A chi-square test found a marginally significant relationship between condition (Nia or Safe in the City) and relationship status at post-test, $X^2(1, N = 97) = 3.699$, $p = .054$. Once again, Safe in the City participants were more likely to be informally married or living with a permanent partner. As there were no significant demographic differences between Nia and Safe in the City, no variables were included as covariates.

Table 8.

Means and SDs for Demographic Variables for the Three Interventions

| Variable | SISTA | | Nia | | Safe in the City | |
|-------------------------------|-------|------|-------|------|------------------|------|
| | Mean | SD | Mean | SD | Mean | SD |
| <i>Age</i> | | | | | | |
| Pre-test | 19.94 | 1.50 | 20.63 | 1.81 | | |
| Post-test | 19.94 | 1.51 | 20.66 | 1.78 | 20.69 | 1.81 |
| Follow-up | 20.45 | 1.52 | 20.96 | 1.85 | 21.04 | 1.89 |
| <i>Education Level</i> | | | | | | |
| Pre-test | 13.58 | 1.20 | 13.75 | 1.28 | | |
| Post-test | 13.53 | 1.49 | 13.76 | 1.56 | 14.07 | 2.08 |
| Follow-up | 13.78 | 1.20 | 13.12 | 3.11 | 14.14 | 2.06 |

Table 9.

Frequencies and Percentages of Single Participants Across the Three Interventions

| Variable | SISTA | | Nia | | Safe in the City | |
|-----------------------------------|--------|---------|--------|---------|------------------|---------|
| | Number | Percent | Number | Percent | Number | Percent |
| <i>Relationship Status</i> | | | | | | |
| Pre-test | 122 | 97.6% | 84 | 100% | | |
| Post-test | 117 | 99.2% | 75 | 98.7% | 85 | 93.4% |
| Follow-up | 128 | 98.5% | 70 | 98.6% | 76 | 91.7% |

Question 7: Did the Raise 5 Project Have Adequate Retention Rates for the Evidence Based Interventions?

A total of 345 students participated in SISTA, Nia, and Safe in the City. However, 18 of these students were not African American. Although the interventions targeted African Americans, a few times students of other racial and ethnic backgrounds signed up and could not be excluded from participation. However, these individuals were excluded from statistical analyses and were not included in the total numbers reached by the project. The 327 African American students made up the final sample. By intervention, there were 139 women who participated in SISTA and 85 men who participated in Nia. These participants completed surveys at pre-test, post-test, and follow-up. Also, 103 men and women participated in Safe in the City. At post-test, 97% (n = 135) of SISTA participants and 89% (n = 76) of Nia participants completed surveys. The overall retention rate at post-test was 94% (n = 211). At follow-up, 94% (n = 131) of SISTA participants, 84% (n = 72) of Nia participants, and 80% (n = 83) of Safe in the City participants completed surveys. Two hundred eighty six participants completed follow-up out of 327 participants for an overall retention rate of 87%.

Summary. The evaluation literature is mixed in regard to what is an acceptable retention rate. Vaillant (1975) suggested that a 5% attrition rate can reduce a study's credibility and those with a 20–25% attrition rate “are probably not worth doing”. However, Polich, Armor, and Braiker (1980) proposed that 70% is an acceptable retention rate. They also suggested that the time and expense necessary for a higher retention rate exceeded the contribution of the added cases to the overall validity. More recent work by Fisher and colleagues (2001) suggests that an 80% retention rate is sufficient. As such, the 87% retention rate for the Raise 5 Project's participants seems more than adequate.

Question 8: Did Participants Across all Evidence Based Interventions Demonstrate Reduced HIV and Substance Use Risk?

Thirteen measures were utilized as the primary outcomes for participants. The means and standard deviations for the continuous outcomes are shown in Table 10. The categorical outcomes are shown in Table 11. The scores on the condom attitude measure range from “1” to “4”, with higher values indicating more negative attitudes towards condoms. At pre-test, the sample reported generally positive condom attitudes, with scores ranging from 1.68 to 1.80. Condom negotiation scores also range from “1” to “4”, with higher values indicating greater condom negotiation skills. The sample had high levels of negotiation skills, with scores ranging from 3.45 to 3.62. Condom efficacy scores ranged from “1” to “3” and higher scores indicated greater condom use efficacy. The sample reported moderately high levels of condom efficacy, with mean scores ranging from 2.44 to 2.72.

HIV testing attitudes ranged from “1” to “7”, with higher values indicating more negative attitudes towards testing. The sample reported positive attitudes towards testing, with mean scores ranging from 1.80 to 1.99. The percentage of students who were tested for HIV ranged from 33.3% to 51.4%. HIV conspiracy belief scores ranged from “1” to “7”, with higher scores indicating stronger belief in HIV conspiracy theories. The sample had moderate attitudes towards conspiracy beliefs, with scores ranging from 2.94 to 3.29. HIV knowledge scores ranged from “1” to “6”, with higher scores indicating greater HIV knowledge. The sample had relatively high levels of HIV knowledge, with scores ranging from 4.68 to 5.00. The percentage who engaged in unprotected oral sex ranged from 54.7% to 70.0%. The percentage who engaged in unprotected vaginal sex ranged from 23.2% to 29.4%. The sample’s average number of sexual partners ranged from 1.03 to 1.23.

The average number of days alcohol was used over the previous 30 days ranged from 3.52 to 4.17. The average number of days the participants got drunk in the past 30 days ranged from 1.81 to 2.29. The average number of days participants used marijuana in the past 30 days ranged from 2.48 to 2.98.

Table 10.

Means and SDs for Outcome Variables

| Variable | Pre | | Post | | Follow-up | |
|-----------------------|------|------|------|------|-----------|------|
| | Mean | SD | Mean | SD | Mean | SD |
| Condom Attitudes | 1.80 | .51 | 1.68 | .47 | 1.80 | .57 |
| Condom Negotiation | 3.45 | .44 | 3.57 | .40 | 3.62 | .38 |
| Condom Efficacy | 2.44 | .52 | 2.70 | .39 | 2.72 | .37 |
| Testing Attitudes | 1.99 | .86 | 1.86 | .86 | 1.80 | .90 |
| Conspiracy Beliefs | 3.29 | .97 | 2.94 | 1.00 | 2.99 | 1.06 |
| HIV Knowledge | 4.68 | 1.00 | 5.00 | .99 | 4.92 | .57 |
| Number of Partners | 1.23 | 1.34 | 1.10 | 1.09 | 1.03 | 1.38 |
| 30 Day Alcohol Use | 4.17 | 4.83 | 3.52 | 4.63 | 3.56 | 4.74 |
| Drunk in Past 30 Days | 2.29 | 4.27 | 2.09 | 4.27 | 1.81 | 3.43 |
| 30 Day Marijuana Use | 2.98 | 7.46 | 2.48 | 6.57 | 2.58 | 6.47 |

Table 11.

Frequencies and Percentages for Outcome Variables

| Variable | Pre | | Post | | Follow-up | |
|---------------------|--------|---------|--------|---------|-----------|---------|
| | Number | Percent | Number | Percent | Number | Percent |
| Tested for HIV | 109 | 33.3% | 168 | 51.4% | 167 | 51.1% |
| Unprotected Oral | 179 | 54.7% | 229 | 70.0% | 218 | 66.7% |
| Unprotected Vaginal | 76 | 23.2% | 96 | 29.4% | 83 | 25.4% |

Pre-test, post-test, and follow-up comparisons: SISTA and Nia. The data analysis plan originally called for a mixed ANOVA to assess between and within subjects differences in outcomes for the three groups. However, Safe in the City was a one session intervention and only post-test and follow-up data were collected. As such, a series of repeated measures ANOVAs and McNemar tests were utilized to compare pre-test, post-test, and follow-up scores for SISTA and Nia participants. Refer to Table 12 for descriptive information on outcome measures for the two intervention groups.

Table 12.

Outcome Means and SDs for SISTA and Nia

| Variable | Pre | | Post | | Follow-up | |
|--------------------|------|------|------|------|-----------|------|
| | Mean | SD | Mean | SD | Mean | SD |
| Condom Attitudes | 1.76 | .48 | 1.66 | .48 | 1.80 | .57 |
| Condom Negotiation | 3.46 | .44 | 3.62 | .36 | 3.68 | .34 |
| Condom Efficacy | 2.41 | .53 | 2.83 | .25 | 2.82 | .27 |
| Testing Attitudes | 1.99 | .86 | 1.82 | .86 | 1.71 | .83 |
| Conspiracy Beliefs | 3.27 | .96 | 2.82 | 1.02 | 2.85 | 1.06 |
| HIV Knowledge | 4.70 | .96 | 5.19 | .91 | 5.06 | 1.02 |
| Number of Partners | 1.17 | 1.18 | 1.06 | 1.10 | 1.12 | 1.62 |

Condom attitudes. A repeated measures ANOVA was performed to assess within subjects changes in condom attitudes. As the assumption of sphericity was violated (Mauchley's $W = .822$, $p < .001$), the Huyhn-Feldt epsilon was used to correct degrees of freedom. The results indicated a statistically significant main effect of time, $F(1.97, 321.65) = 7.181$, $p = .002$, partial $\eta^2 = .037$. Post hoc tests using the Bonferroni correction revealed a significant reduction in negative condom attitudes from pre-test ($M = 1.76$, $SD = .48$) to post-test ($M = 1.66$, $SD = .48$), $p = .002$. However, there was a significant increase in negative condom attitudes at follow-up ($M = 1.80$, $SD = .57$), $p = .003$ (see Figure 2). These results suggest that participation in SISTA and Nia reduced negative condom attitudes during the interventions. However, these reductions were not maintained at three month follow-up.

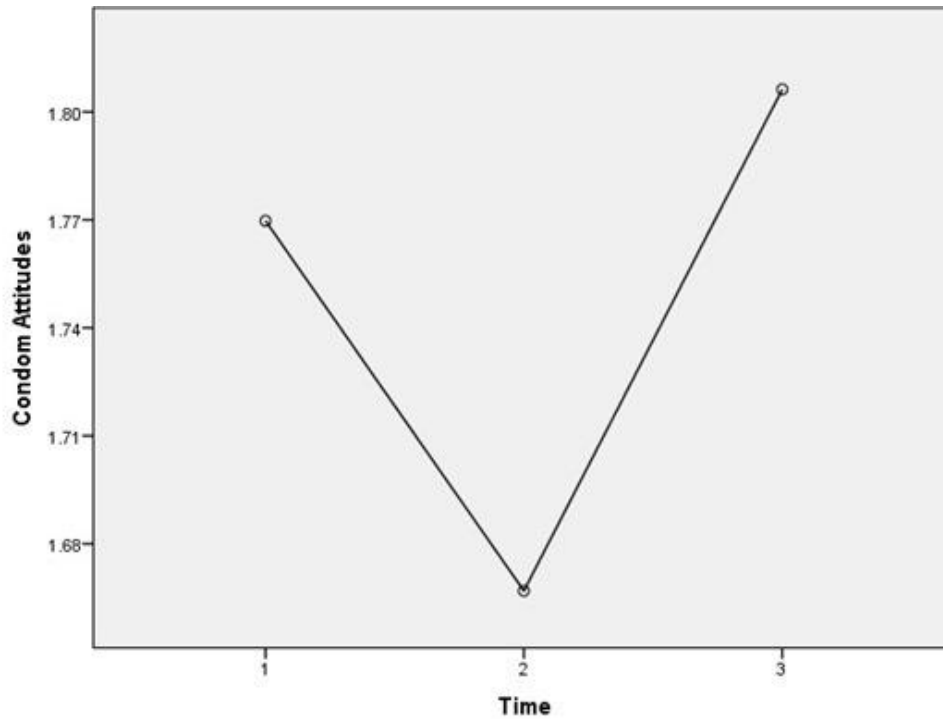


Figure 2. SISTA and Nia Condom Attitude Scores

Condom negotiation. The assumption of sphericity was violated (Mauchley's $W = .921$, $p < .001$) for the condom negotiation measure. As such, the Huyhn-Feldt epsilon was used to correct degrees of freedom. The results indicated a statistically significant main effect of time, $F(1.87, 353.62) = 27.70$, $p < .001$, partial $\eta^2 = .128$. Post hoc tests with the Bonferroni correction showed a significant increase in condom negotiation skills from pre-test ($M = 3.46$, $SD = .44$) to post-test ($M = 3.62$, $SD = .36$), $p < .001$. Also, there was a marginally significant difference in condom negotiation scores from post-test to follow-up ($M = 3.68$, $SD = .34$), $p = .055$. The difference from pre-test to follow-up was significant, $p < .001$ (see Figure 3). As such, participants of SISTA and Nia had statistically significant increases in condom negotiation at post-test, which were maintained at follow-up.

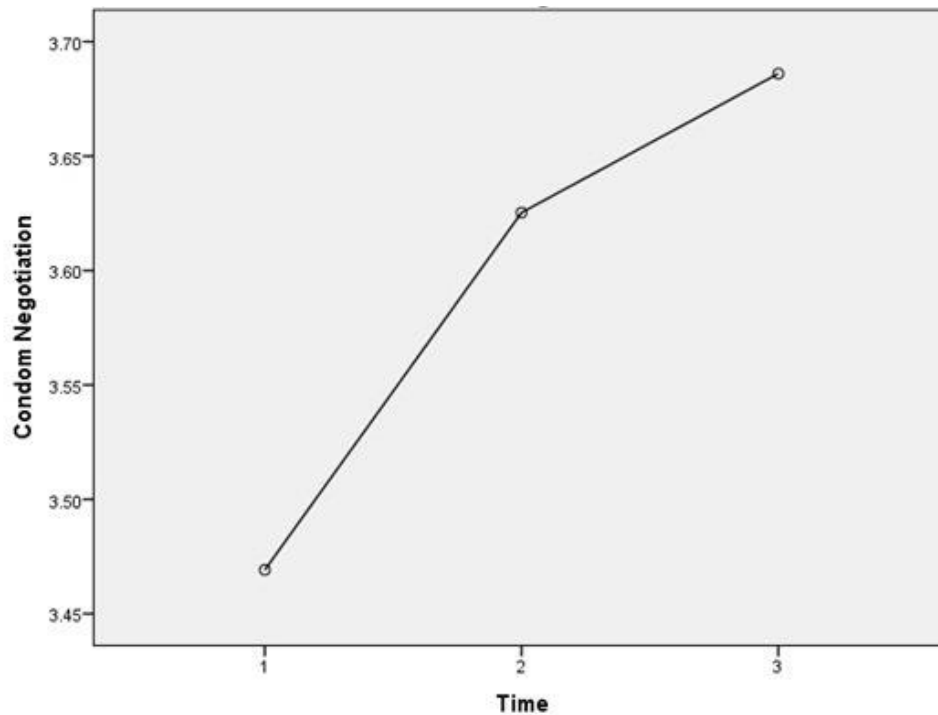


Figure 3. SISTA and Nia Condom Negotiation Scores

Condom efficacy. The assumption of sphericity was violated (Mauchley's $W = .558$, $p < .001$) for the condom efficacy measure. Because the epsilon value was less than .75, the Greenhouse-Geisser epsilon was used to correct degrees of freedom. There was a statistically significant main effect of time, $F(1.38, 263.47) = 131.61$, $p < .001$, partial $\eta^2 = .409$. Post hoc tests using the Bonferroni correction indicate a significant increase in condom efficacy from pre-test ($M = 2.41$, $SD = .53$) to post-test ($M = 2.83$, $SD = .25$), $p < .001$. There was no significant difference in condom efficacy from post-test to follow-up ($M = 2.82$, $SD = .27$), $p = .055$. However, the difference from pre-test to follow-up was significant, $p < .001$ (see Figure 4). This indicates that SISTA and Nia participants demonstrated increased condom use efficacy from pre-test to post-test, which was maintained at follow-up.

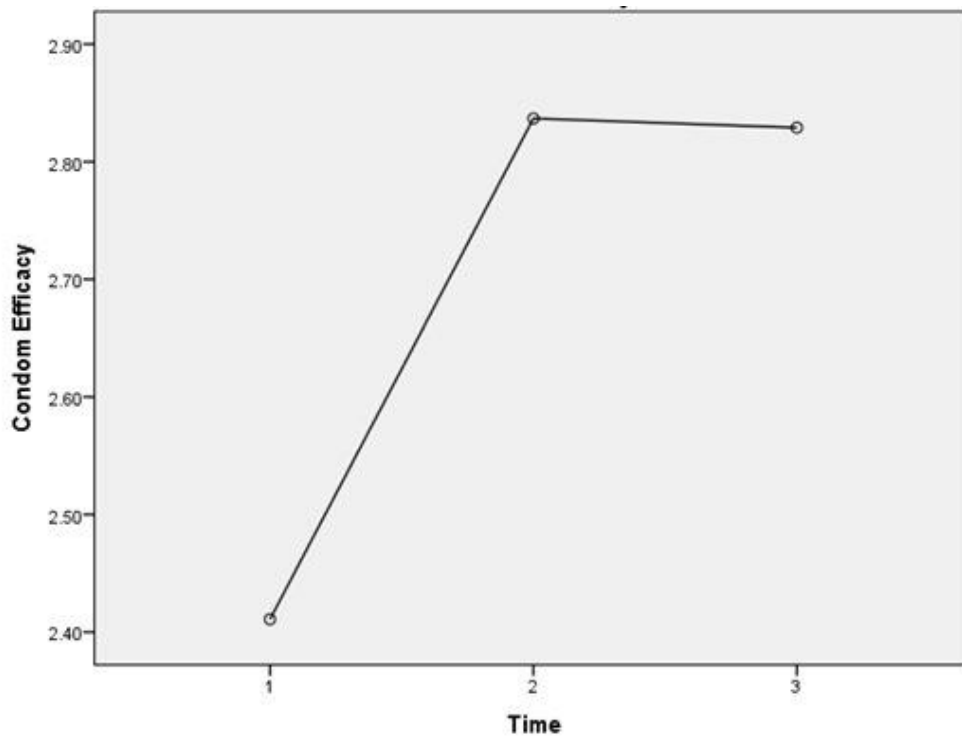


Figure 4. SISTA and Nia Condom Efficacy Scores

Testing attitudes. The assumption of sphericity was met (Mauchley's $W = .997$, $p = .763$) for the testing attitude measure. As such, no correction was used. The results indicated a statistically significant main effect of time, $F(2, 378) = 8.532$, $p < .001$, partial $\eta^2 = .043$. Post hoc tests using the Bonferroni correction demonstrated a significant decrease in negative testing attitudes from pre-test ($M = 1.99$, $SD = .86$) to post-test ($M = 1.82$, $SD = .86$), $p = .041$. There was no significant difference in testing attitudes from post-test to follow-up ($M = 1.71$, $SD = .83$), $p = .344$. However, the difference from pre-test to follow-up was significant, $p < .001$ (see Figure 5). These findings suggest that SISTA and Nia participants had a statistically significant decrease in negative HIV testing attitudes from pre-test to post-test. This decrease was maintained at follow-up.

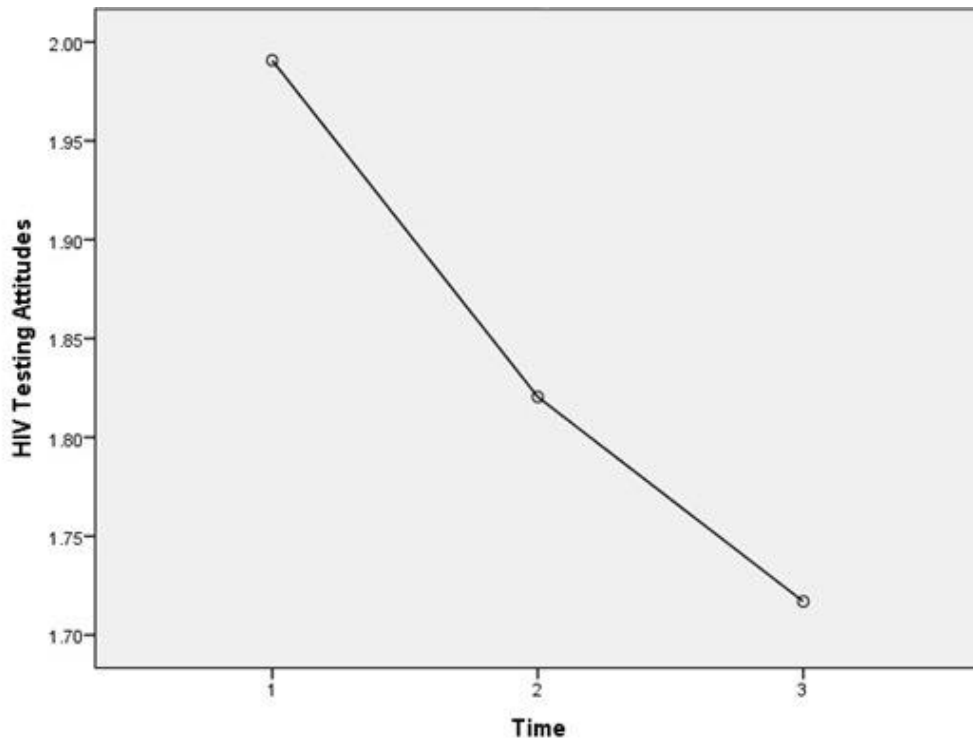


Figure 5. SISTA and Nia HIV Testing Attitude Scores

Conspiracy beliefs. The assumption of sphericity was met (Mauchley's $W = .981$, $p = .167$) for the conspiracy beliefs scale. As such, no correction was used. The results showed a statistically significant main effect of time, $F(2, 378) = 36.85$, $p < .001$, partial $\eta^2 = .163$. Post hoc tests using the Bonferroni correction indicated a significant decrease in HIV conspiracy beliefs from pre-test ($M = 3.27$, $SD = .96$) to post-test ($M = 2.82$, $SD = 1.02$), $p < .001$. There was no significant difference in conspiracy beliefs from post-test to follow-up ($M = 2.85$, $SD = 1.06$), $p = 1.00$. However, the difference from pre-test to follow-up was significant, $p < .001$ (see Figure 6). As such, these findings suggest that participants in SISTA and Nia had statistically significant decreases in HIV conspiracy beliefs from pre-test to post-test. This significant decrease was maintained at follow up.

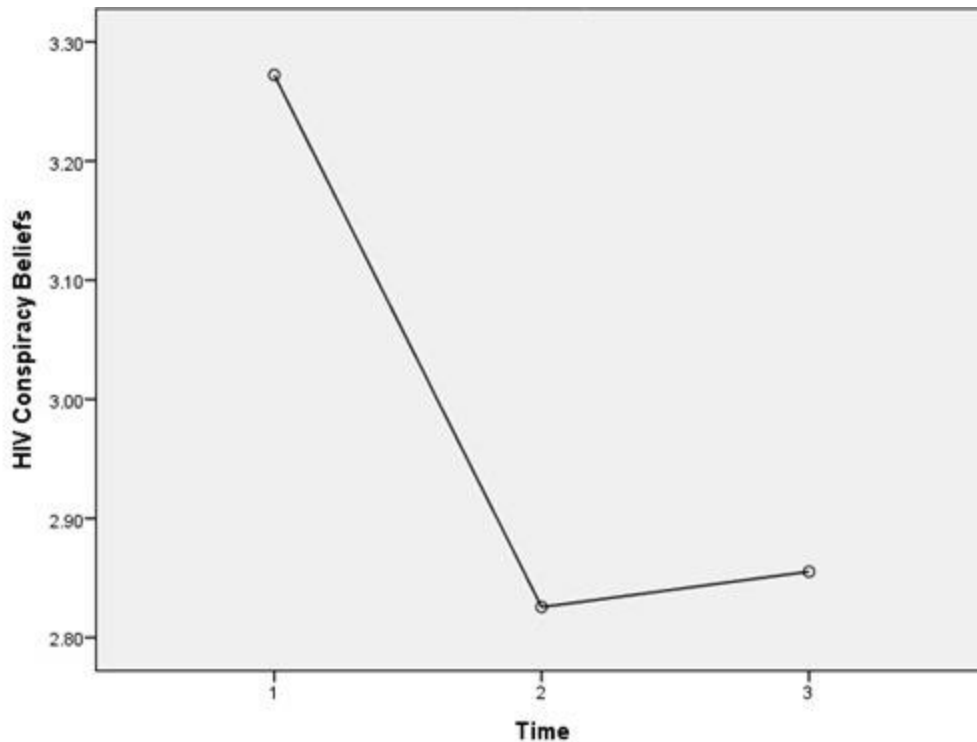


Figure 6. SISTA and Nia HIV Conspiracy Belief Scores

HIV knowledge. The assumption of sphericity was met (Mauchley's $W = .986$, $p = .263$) for HIV knowledge. As such, no correction was used. The results indicated a statistically significant main effect of time, $F(2, 340) = 9.603$, $p < .001$, partial $\eta^2 = .053$. Post hoc tests using the Bonferroni correction showed a significant increase in HIV knowledge from pre-test ($M = 4.70$, $SD = .96$) to post-test ($M = 5.19$, $SD = .91$), $p < .001$. There was no significant difference in HIV knowledge from post-test to follow-up ($M = 5.06$, $SD = 1.02$), $p = .420$. However, the difference from pre-test to follow-up was significant, $p < .001$ (see Figure 7). This suggests that participants in SISTA and Nia had statistically significant increases in their HIV knowledge from pre-test to post-test. These increases in knowledge were maintained at follow-up.

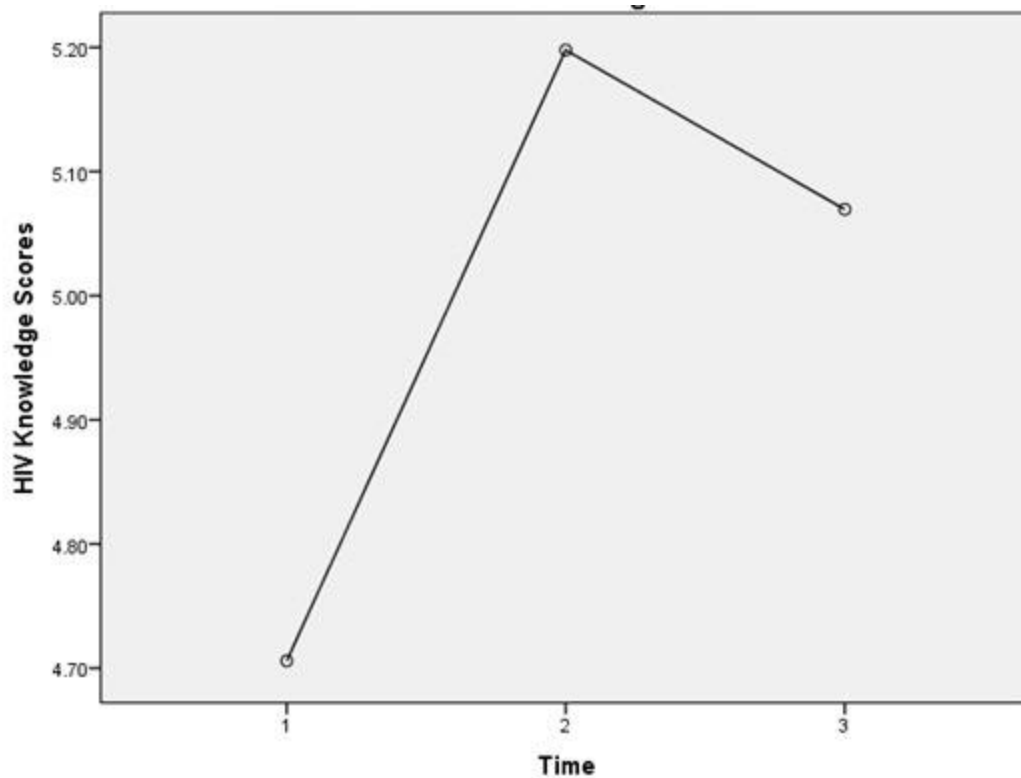


Figure 7. SISTA and Nia HIV Knowledge Scores

Sex and HIV testing outcomes. A series of repeated measures ANOVAs and McNemar tests were computed to assess time differences on sexual risk outcomes. Refer to Table 12 for descriptive information on outcomes. The first ANOVA examined changes in the number of partners. The assumption of sphericity was violated (Mauchley's $W = .794$, $p < .001$). As such, the Huyhn-Feldt epsilon was used to correct degrees of freedom. There was no statistically significant main effect of time, $F(1.67, 294.42) = .748$, $p = .425$, partial $\eta^2 = .002$.

A series of McNemar's tests were performed to assess changes in HIV testing and unprotected sex. The first McNemar's test determined there was no significant difference in unprotected oral sex between pre-test and post-test, $p = .210$. There was also no significant change in unprotected oral sex between post-test and follow-up, $p = .999$. There was a

marginally significant change in unprotected oral sex between pre-test and follow-up, $p = .057$. Another analysis found a marginally significant difference in unprotected vaginal sex between pre-test and post-test, $p = .067$. However, there was no significant difference in unprotected vaginal sex between post-test and follow-up, $p = .877$. Also, there was no significant difference in unprotected vaginal sex between pre-test and follow-up, $p = .185$.

Another McNemar's test found there was a marginally significant difference in HIV testing between pre-test and post-test, $p = .093$. The next analysis found a significant difference between HIV testing from post-test to follow-up, $p = .005$. There was also a significant difference in testing from pre-test to follow-up, $p < .001$. These findings indicated that a greater percent of participants had received a HIV test after completing SISTA or Nia.

Table 13.

Unprotected Sex and HIV Testing for SISTA and Nia Participants

| Variable | Pre | | Post | | Follow-up | |
|---------------------|--------|---------------|--------|---------------|-----------|---------------|
| | Number | Valid Percent | Number | Valid Percent | Number | Valid Percent |
| Tested for HIV | 109 | 49.3% | 108 | 52.9% | 119 | 60.7% |
| Unprotected Oral | 179 | 95.7% | 160 | 90.4% | 155 | 90.1% |
| Unprotected Vaginal | 76 | 42.0% | 60 | 34.7% | 61 | 34.1% |

Drug outcomes. A series of repeated measures ANOVAs were used to assess drug use outcomes. See Table 13 for descriptive information on drug outcomes among SISTA and Nia participants. The first analysis assessed 30 day alcohol use. The assumption of sphericity was

violated (Mauchley's $W = .941$, $p = .004$). As such, the Huyhn-Feldt epsilon was used to correct degrees of freedom. There was a marginally significant main effect of time, $F(1.907, 352.71) = 2.672$, $p = .073$, partial $\eta^2 = .014$.

The next repeated measures ANOVA assessed how many times participants got drunk in the past 30 days. The assumption of sphericity was met (Mauchley's $W = .969$, $p = .057$). As such, no correction was used. There was no significant difference across the three time points, $F(2, 360) = .369$, $p = .692$, partial $\eta^2 = .002$.

The final analysis assessed changes in 30 day marijuana use. The assumption of sphericity was violated (Mauchley's $W = .843$, $p < .000$). As such, the Huyhn-Feldt epsilon was used to correct degrees of freedom. There was no statistically significant main effect of time, $F(1.74, 308.67) = .530$, $p = .565$, partial $\eta^2 = .003$.

Table 14.

Means and SDs of Drug Outcomes for SISTA and Nia

| Variable | Pre-test | | Post-test | | Follow-up | |
|---------------|----------|------|-----------|------|-----------|------|
| | Mean | SD | Mean | SD | Mean | SD |
| Past 30 Days | | | | | | |
| Alcohol Use | 3.90 | 4.64 | 3.15 | 4.32 | 3.35 | 4.82 |
| Got Drunk | 1.78 | 3.22 | 1.82 | 3.96 | 1.61 | 3.31 |
| Marijuana Use | 2.38 | 6.49 | 2.11 | 6.33 | 2.06 | 5.91 |

Summary. Participation in SISTA and Nia significantly reduced negative condom attitudes from pre-test to post-test. However, the negative condom attitude scores increased at

follow-up. These findings suggest that the interventions were effective at reducing negative condom attitudes, but the reductions could not be maintained at three month follow-up. Participation also led to statistically significant increases in condom negotiation, condom efficacy, and HIV knowledge from pre-test to post-test. These increases were maintained at follow-up. Participation in SISTA and Nia also led to statistically significant decreases in negative HIV testing attitudes and conspiracy beliefs from pre-test to post-test. These decreases were also maintained at follow-up. Analyses also indicated there was a statistically significant increase in the percentage of participants who received an HIV test, suggesting that a greater percent of participants had received a HIV test after completing SISTA or Nia.

Post-test to follow-up comparisons: Safe in the City. A second series of analyses were performed to assess changes from post-test to follow-up among Safe in the City participants. See Table 15 for descriptive information on outcome variables.

Table 15.

Means and SDs of Outcome Measures for SITC

| Variable | Post-test | | Follow-up | |
|--------------------|-----------|-----|-----------|------|
| | Mean | SD | Mean | SD |
| Condom Attitudes | 1.61 | .42 | 1.77 | .53 |
| Condom Negotiation | 3.50 | .41 | 3.52 | .44 |
| Condom Efficacy | 2.43 | .45 | 2.49 | .45 |
| Testing Attitudes | 1.94 | .86 | 1.90 | .91 |
| Conspiracy Beliefs | 3.11 | .91 | 3.21 | .97 |
| HIV Knowledge | 4.71 | .98 | 4.65 | 1.01 |
| Number of Partners | 1.03 | .77 | .87 | .75 |

Condom attitudes. A repeated measures ANOVA was conducted to assess if Safe in the City participants had significant changes in their condom attitudes from post-test and follow-up. The assumption of sphericity was not relevant because there were only two levels of repeated measures. As such, there was only one set of difference scores and nothing to compare to indicate a violation of sphericity. The results indicated there was a statistically significant main effect of time, $F(1, 82) = 9.746, p = .002$, partial $\eta^2 = .106$. Post hoc tests using the Bonferroni correction indicated a significant increase in negative condom attitudes from post-test ($M = 1.61$, $SD = .42$) to follow-up ($M = 1.77$, $SD = .53$), $p = .002$ (see Figure 8).

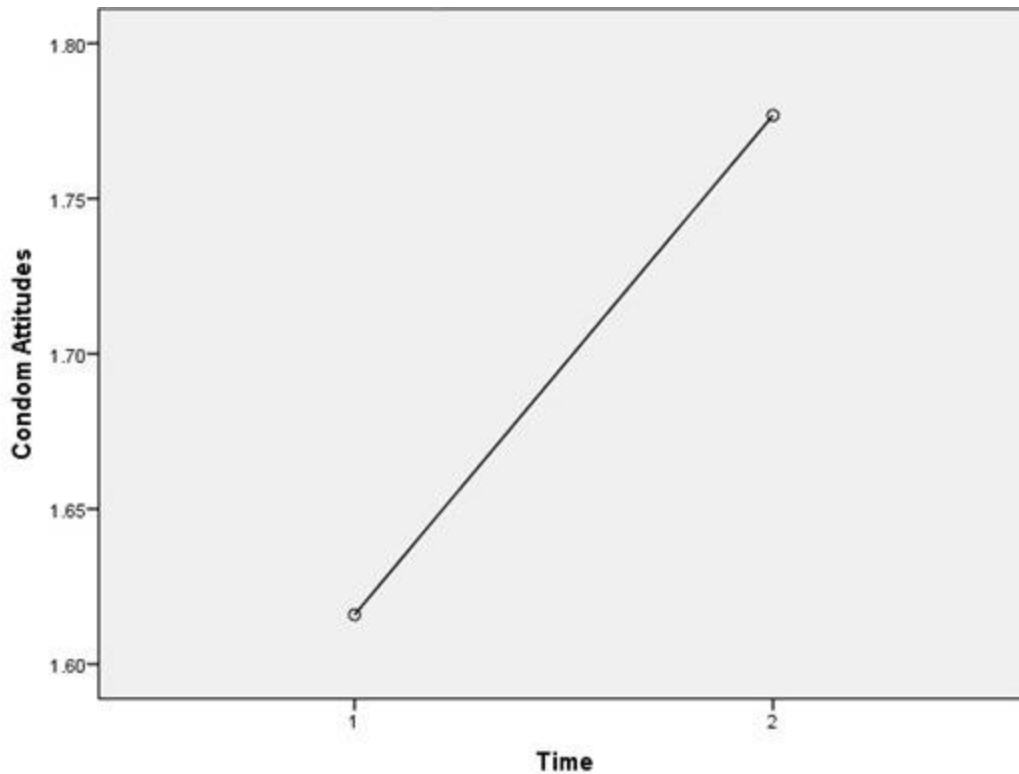


Figure 8. Safe in the City Condom Attitude Scores

Additional outcome variables. There was no significant change for the other outcome variables. A repeated measures ANOVA indicated there was no statistically significant main effect of time on: 1) *condom negotiation*, $F(1, 82) = .073$, $p = .787$, partial $\eta^2 = .001$, 2) *condom efficacy*, $F(1, 82) = 2.071$, $p = .154$, partial $\eta^2 = .025$, 3) *HIV testing attitudes*, $F(1, 82) = .194$, $p = .661$, partial $\eta^2 = .002$, 4) *HIV conspiracy beliefs*, $F(1, 83) = 1.462$, $p = .230$, partial $\eta^2 = .017$, and 5) *HIV knowledge*, $F(1, 83) = .285$, $p = .595$, partial $\eta^2 = .003$.

Sex and HIV testing outcomes. Analyses were conducted to assess changes in three sexual outcomes: number of partners, unprotected oral sex, and unprotected vaginal sex. See Table 16 for descriptive information on sexual risk outcomes. The results of a repeated measures ANOVA indicated there was a significant change in Safe in the City participants' number of

sexual partners over the past three months, $F(1, 74) = 4.429$, $p = .039$, partial $\eta^2 = .056$. Post hoc tests using the Bonferroni correction demonstrated a significant decline in the number of sexual partners from post-test ($M = 1.03$, $SD = .77$) to follow-up ($M = .87$, $SD = .75$), $p = .039$ (see Figure 9). Thus, Safe in the City participants had a statistically significant decrease in number of sexual partners from post-test to follow-up. A series of McNemar's tests were performed to assess changes in and unprotected sex and HIV testing. Also, there were no significant differences in unprotected oral sex ($p = .999$) and unprotected vaginal sex ($p = .302$) between post-test and follow-up. Also there was no significant difference in HIV testing from post-test to follow-up, $p = .219$.

Table 16.

Unprotected Sex and HIV Testing for SITC Participants

| Variable | Post-test | | Follow-up | |
|---------------------|-----------|---------------|-----------|---------------|
| | Number | Valid Percent | Number | Valid Percent |
| Tested for HIV | 60 | 59.4% | 48 | 60.0% |
| Unprotected Oral | 69 | 90.8% | 63 | 90.0% |
| Unprotected Vaginal | 36 | 46.8% | 22 | 31.0% |

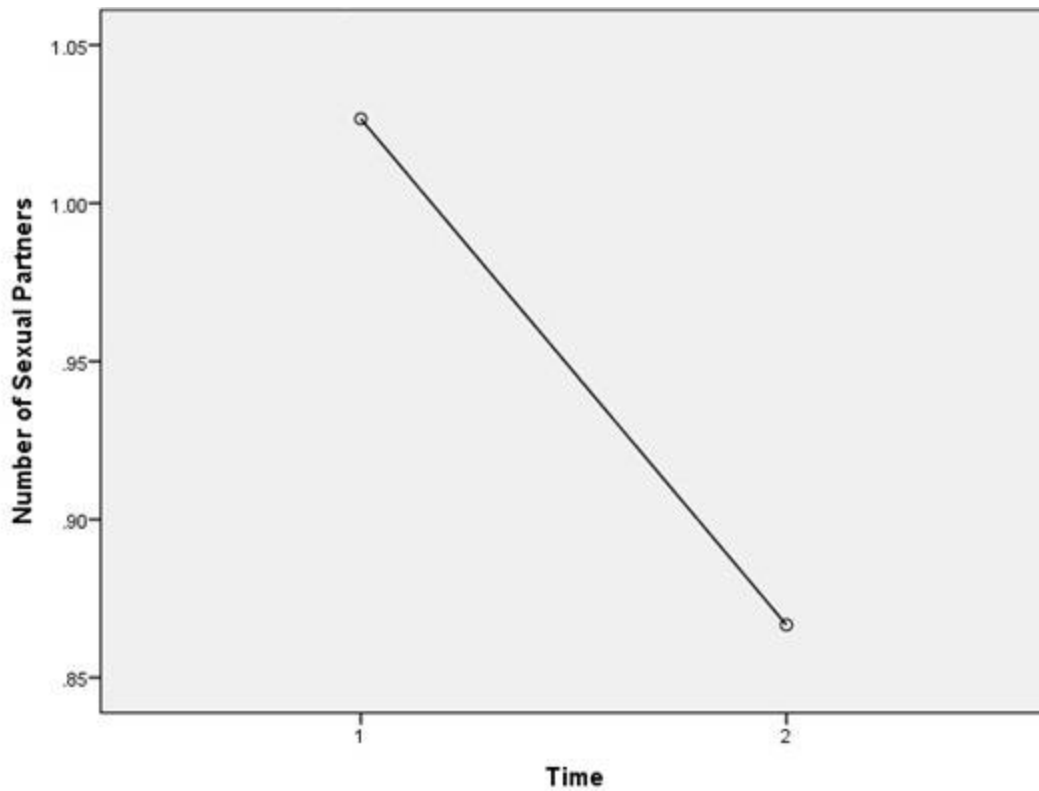


Figure 9. Safe in the City Number of Partners Over Past Three Months

Drug outcomes. A series of repeated measures ANOVAs were conducted to assess changes in drug use. Refer to Table 17 for descriptive information on drug outcomes for Safe in the City. There was no statistically significant main effect of time on 30 day alcohol use, $F(1, 67) = .578, p = .450$, partial $\eta^2 = .009$. There was no significant difference in the number of days participants got drunk, $F(1, 70) = .988, p = .324$, partial $\eta^2 = .014$. Also, there was no statistically significant difference in 30 day marijuana use, $F(1, 71) = .131, p = .719$, partial $\eta^2 = .002$.

Table 17.

Means and SDs of Drug Outcomes for SITC

| Variable | Post-test | | Follow-up | |
|--------------|-----------|------|-----------|------|
| | Mean | SD | Mean | SD |
| Past 30 Days | | | | |
| Alcohol | 4.06 | 4.99 | 3.68 | 4.49 |
| Drunk | 2.23 | 4.16 | 1.77 | 3.04 |
| Marijuana | 2.03 | 4.85 | 2.18 | 4.71 |

Summary. Safe in the City participants demonstrated a significant increase in negative condom attitudes from post-test to follow-up. The results also indicated that Safe in the City participants had a significant decrease in number of sexual partners over the previous three months. There were no other statistically significant differences from post-test to follow-up for sexual risk or drug use outcomes.

Question 9: Did Women Who Participated in SISTA Have Reduced HIV and Substance Use Risk Compared to Women in Safe in the City?

SISTA vs SITC: Post-test comparisons. An additional series of ANCOVAs were computed to compare outcomes between women in SISTA and Safe in the City at post-test. Age, education level, and relationship status were included as covariates. See Table 18 for descriptive information for SISTA and Safe in the City at post-test.

Table 18.

Means and SDs for Outcome Measures at Post-test for SISTA and SITC

| Variable | SISTA | | Safe in the City | |
|--------------------|-------|-----|------------------|------|
| | Mean | SD | Mean | SD |
| Condom Attitudes | 1.50 | .44 | 1.60 | .44 |
| Condom Negotiation | 3.68 | .29 | 3.55 | .42 |
| Condom Efficacy | 2.81 | .28 | 2.32 | .46 |
| Testing Attitudes | 1.71 | .77 | 1.90 | .83 |
| Conspiracy Beliefs | 2.49 | .90 | 2.98 | .97 |
| HIV Knowledge | 5.29 | .93 | 4.67 | 1.13 |
| Number of Partners | .91 | .72 | .97 | .77 |

Condom attitudes. The ANCOVA for condom attitudes had no statistically significant main effect, $F(1,177) = 1.523$, $p = .219$. There was no significant difference in post-test condom attitudes between women in SISTA ($M = 1.50$, $SD = .44$) and Safe in the City ($M = 1.60$, $SD = .44$).

Condom negotiation. The ANCOVA for differences in condom negotiation had a statistically significant main effect, $F(1,177) = 6.833$, $p = .010$. Women in SISTA ($M = 1.50$, $SD = .44$) had significantly greater condom negotiation scores than those in Safe in the City ($M = 1.60$, $SD = .44$) (see Figure 10).

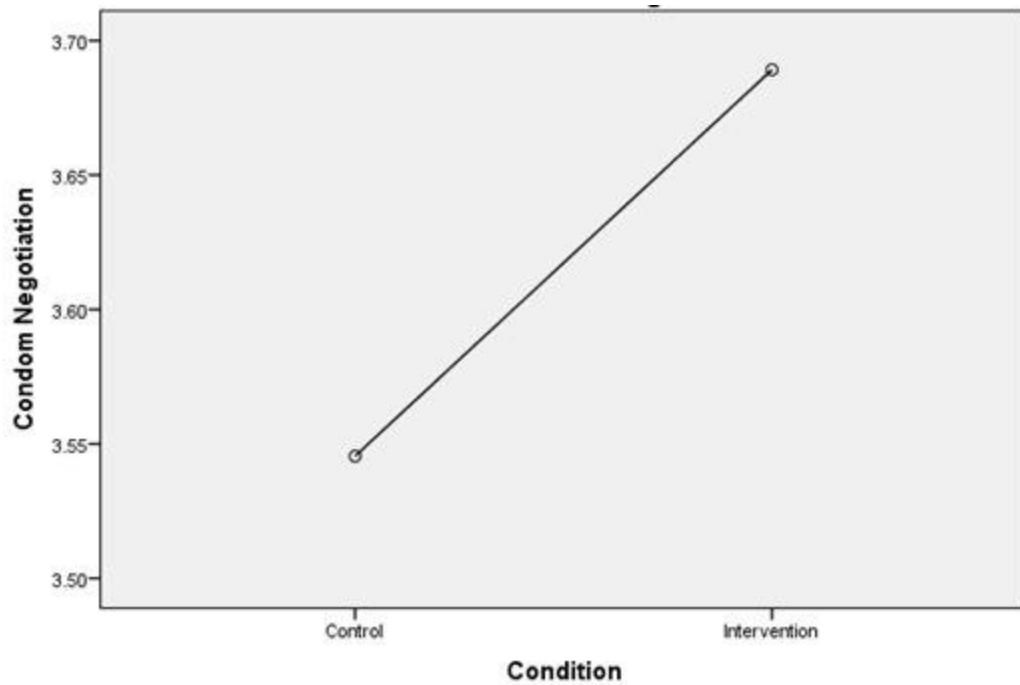


Figure 10. SISTA vs SITC: Post-test Condom Negotiation

Condom efficacy. The ANCOVA for differences in condom efficacy had a statistically significant main effect, $F(1,177) = 78.083, p < .001$. Women in SISTA ($M = 2.81, SD = .28$) had significantly greater condom efficacy scores than those in Safe in the City ($M = 2.32, SD = .46$) (See Figure 11).

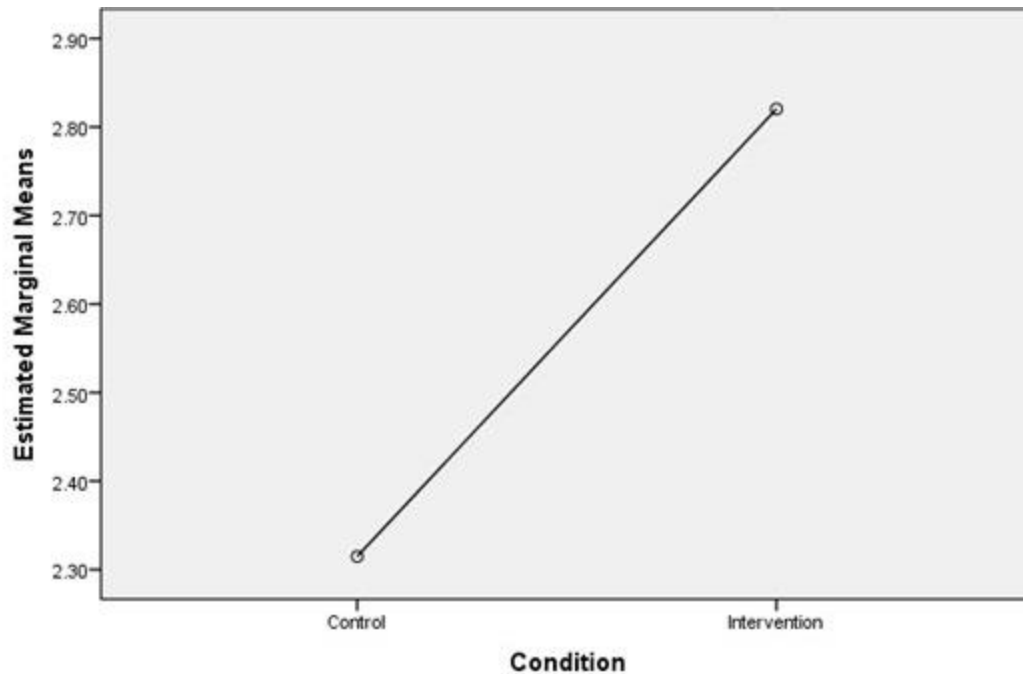


Figure 11. SISTA vs SITC: Post-test Condom Efficacy

Testing attitudes. There were no significant differences in HIV testing attitudes at post-test between women in SISTA ($M = 1.71$, $SD = .77$) and those in Safe in the City ($M = 1.90$, $SD = .83$, $F(1,179) = 3.309$, $p = .071$).

Conspiracy beliefs. The ANCOVA for differences in conspiracy beliefs had a statistically significant main effect, $F(1,179) = 12.768$, $p < .001$. Women who participated in Safe in the City ($M = 2.98$, $SD = .97$) had significantly higher post-test conspiracy belief scores than those who participated in SISTA ($M = 2.49$, $SD = .90$) (see Figure 12).

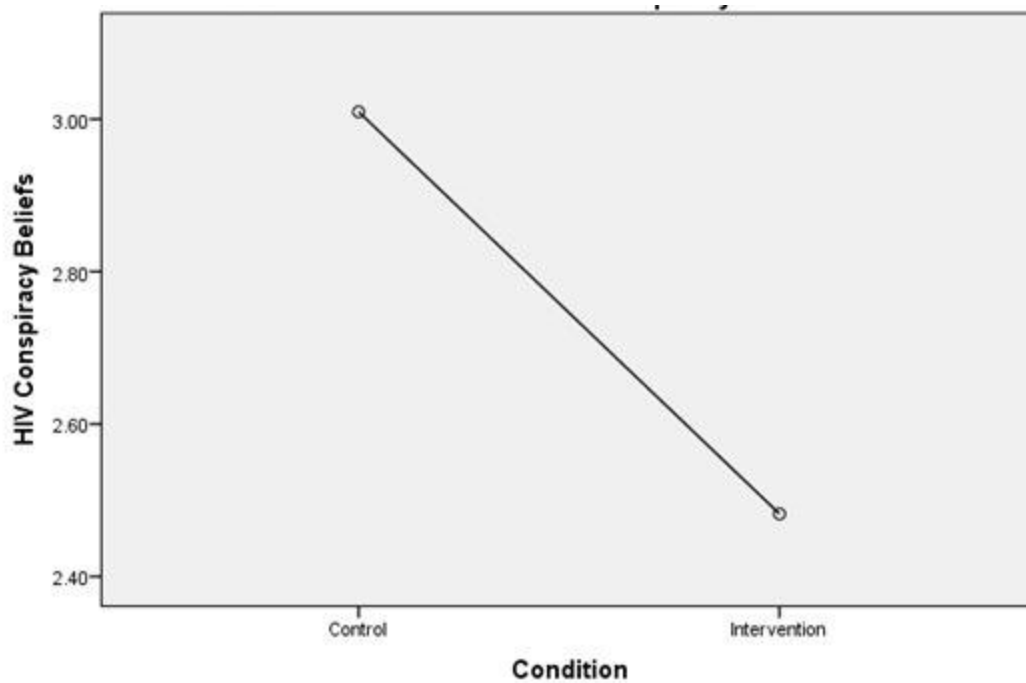


Figure 12. SISTA vs SITC: Post-test HIV Conspiracy Beliefs

HIV knowledge. The ANCOVA for differences in HIV knowledge had a statistically significant main effect, $F(1,179) = 13.939$, $p < .001$. Women in SISTA ($M = 5.29$, $SD = .93$) had significantly higher post-test HIV knowledge scores than those in Safe in the City ($M = 4.67$, $SD = 1.13$) (see Figure 13).

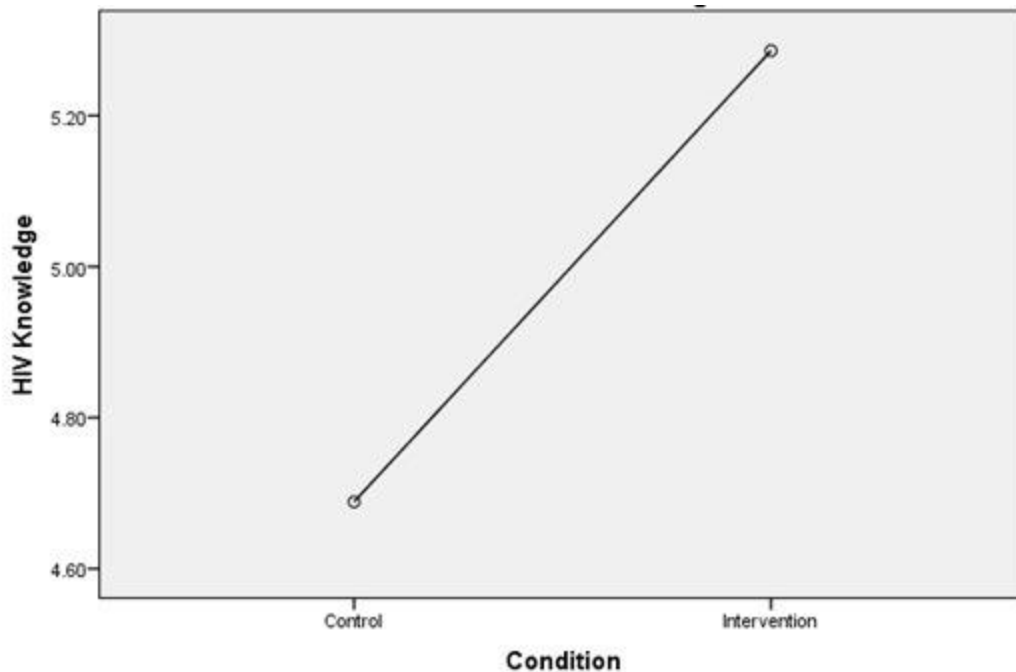


Figure 13. SISTA vs SITC: Post-test HIV Knowledge

Sex and HIV testing outcomes. An ANCOVA found no significant difference in the number of partners at post-test between women in SISTA ($M = .91$, $SD = .72$) and those in Safe in the City ($M = .97$, $SD = .77$), $F(1,179) = .580$, $p = .447$. Chi-square tests were also computed to assess differences in HIV testing and unprotected sex. At post-test, the relationship between condition (SISTA or Safe in the City) and unprotected oral sex was not significant, $X^2(1, N = 173) = .107$, $p = .744$. However, the relationship between condition and unprotected vaginal sex was significant, $X^2(1, N = 165) = 4.083$, $p = .043$. SISTA participants were more likely to engage in protected vaginal sex than those in those in Safe in the City at post-test. At post-test, the relationship between condition (SISTA or Safe in the City) and HIV testing was not significant, $X^2(1, N = 206) = .356$, $p = .551$. Refer to Table 19 for descriptive information on categorical sex outcomes.

Table 19.

Unprotected Sex and HIV Testing at Post-test for SISTA and SITC Participants

| Variable | SISTA | | Safe in the City | |
|---------------------|--------|---------------|------------------|---------------|
| | Number | Valid Percent | Number | Valid Percent |
| Tested for HIV | 73 | 55.7% | 45 | 60.0% |
| Unprotected Oral | 104 | 89.7% | 52 | 91.2% |
| Unprotected Vaginal | 39 | 37.1% | 32 | 53.3% |

Drug outcomes. A series of ANCOVAs were performed to assess differences in drug use between women in SISTA and Safe in the City. Refer to Table 20 for descriptive information on drug outcomes. An ANCOVA found a marginally significant difference in post-test 30 day alcohol use, $F(1, 173) = 3.482, p = .064$. Women in SISTA ($M = 2.25, SD = 3.21$) had lower levels of alcohol use than those in Safe in the City ($M = 3.33, SD = 4.00$). There were no significant difference in days SISTA and Safe in the City participants got drunk at post-test, $F(1, 173) = 1.340, p = .249$. There was also no significant difference in 30 day marijuana use between SISTA and Safe in the City participants at post-test, $F(1, 175) = .009, p = .923$.

Table 20.

Means and SDs of Drug Outcomes at Post-test for SISTA and SITC

| Variable | SISTA | | SITC | |
|---------------|-------|------|------|------|
| | Mean | SD | Mean | SD |
| Past 30 Days | | | | |
| Alcohol Use | 2.25 | 3.21 | 3.33 | 4.00 |
| Got Drunk | 1.28 | 2.86 | 1.75 | 2.95 |
| Marijuana Use | 1.41 | 4.53 | 1.23 | 3.29 |

Summary. There were a number of significant differences between women in SISTA and Safe in the City at post-test. A series of ANCOVAs indicated that SISTA participants had significantly greater levels of condom negotiation skills, condom use efficacy, and HIV knowledge after their intervention concluded. In addition, a chi-square test indicated that women in SISTA were significantly more likely to engage in protected vaginal sex. Women in Safe in the City demonstrated a significantly greater endorsement of HIV conspiracy beliefs.

SISTA vs SITC: Follow-up comparisons. An additional series of ANCOVAs were computed to compare outcomes between women in SISTA and Safe in the City at three month follow-up. Post-test scores for age, education level, and relationship status were included as covariates. Refer to Table 21 for descriptive information on outcome measures at follow-up.

Table 21.

Means and SDs for Outcome Measures at Follow-up for SISTA and SITC

| Variable | SISTA | | Safe in the City | |
|--------------------|-------|------|------------------|-----|
| | Mean | SD | Mean | SD |
| Condom Attitudes | 1.69 | .59 | 1.73 | .60 |
| Condom Negotiation | 3.74 | .30 | 3.54 | .44 |
| Condom Efficacy | 2.80 | .30 | 2.39 | .43 |
| Testing Attitudes | 1.53 | .71 | 1.86 | .92 |
| Conspiracy Beliefs | 2.58 | 1.00 | 2.97 | .97 |
| HIV Knowledge | 5.24 | .88 | 4.81 | .87 |
| Number of Partners | .91 | .76 | .87 | .72 |

Condom attitudes. The ANCOVA for condom attitudes had no statistically significant main effect, $F(1,160) = .152, p = .697$. As such, there was no significant difference in condom attitudes at follow-up between women in SISTA ($M = 1.69, SD = .59$) and those in Safe in the City ($M = 1.73, SD = .60$).

Condom negotiation. The ANCOVA on condom negotiation had a statistically significant main effect, $F(1,161) = 10.155, p = .002$ and women in SISTA ($M = 3.74, SD = .30$) had significantly greater condom negotiation scores at follow-up than those in Safe in the City ($M = 3.54, SD = .44$) (see Figure 14).

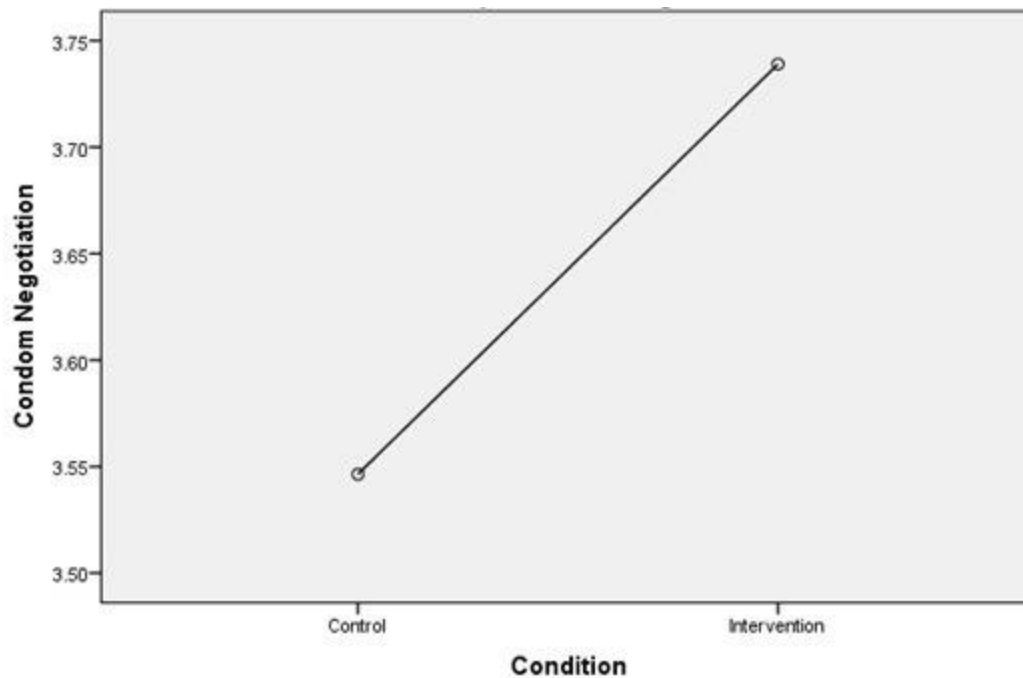


Figure 14. SISTA vs SITC: Follow-up Condom Negotiation

Condom efficacy. The ANCOVA assessing differences in condom efficacy had a statistically significant main effect, $F(1,160) = 43.055, p < .001$. Women in SISTA ($M = 2.80$, $SD = .30$) had significantly greater condom efficacy scores at follow-up than those in Safe in the City ($M = 2.39$, $SD = .43$) (see Figure 15).

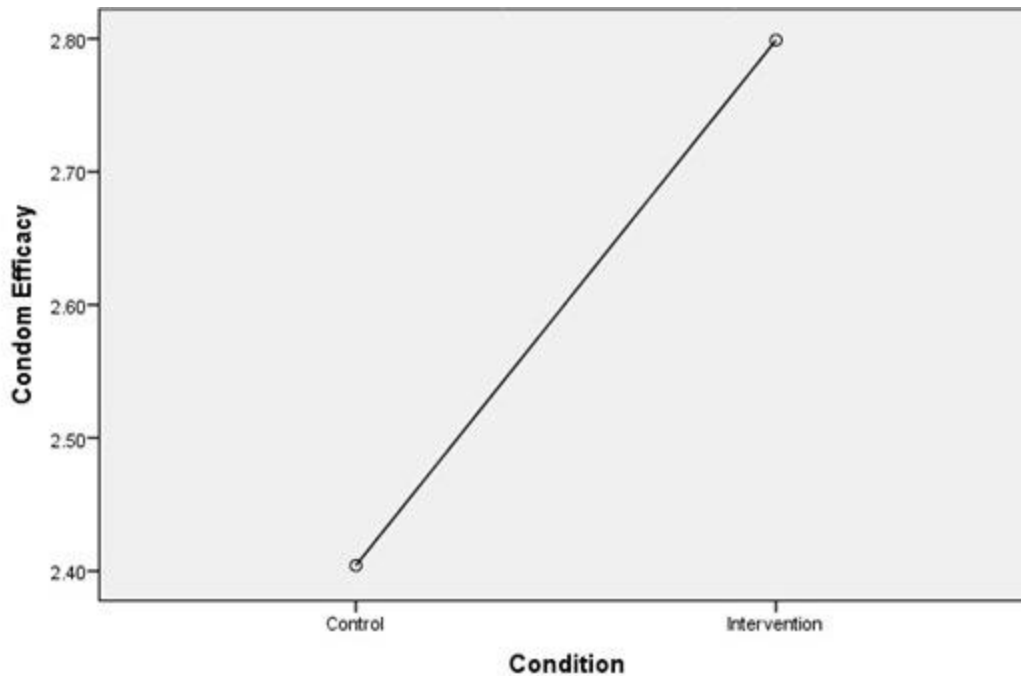


Figure 15. SISTA vs SITC: Follow-up Condom Efficacy

HIV testing attitudes. The ANCOVA assessing differences in HIV testing attitudes had a statistically significant main effect, $F(1,160) = 5.917, p = .016$. Women in Safe in the City ($M = 1.86, SD = .92$) had significantly more negative HIV testing attitude scores at follow-up than those in SISTA ($M = 1.53, SD = .71$) (see Figure 16).

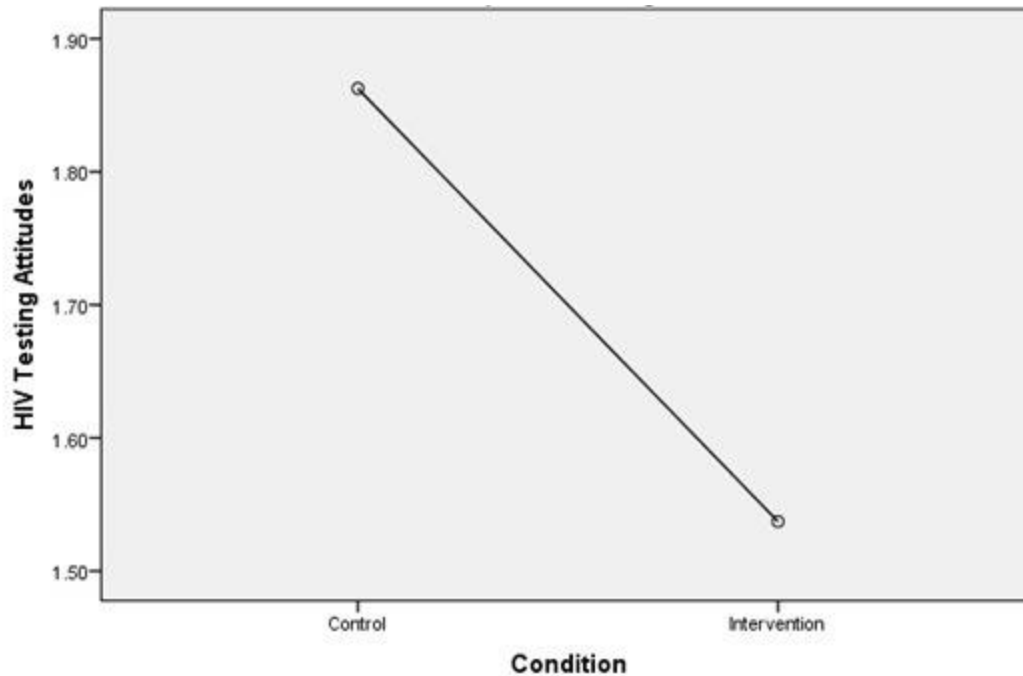


Figure 16. SISTA vs SITC: Follow-up HIV Testing Attitudes

Conspiracy beliefs. The ANCOVA on conspiracy beliefs had a statistically significant main effect, $F(1,160) = 5.948, p = .016$. Women participating in Safe in the City ($M = 2.97, SD = .97$) had significantly higher conspiracy belief scores at follow-up than those in SISTA ($M = 2.58, SD = 1.00$) (see Figure 17).

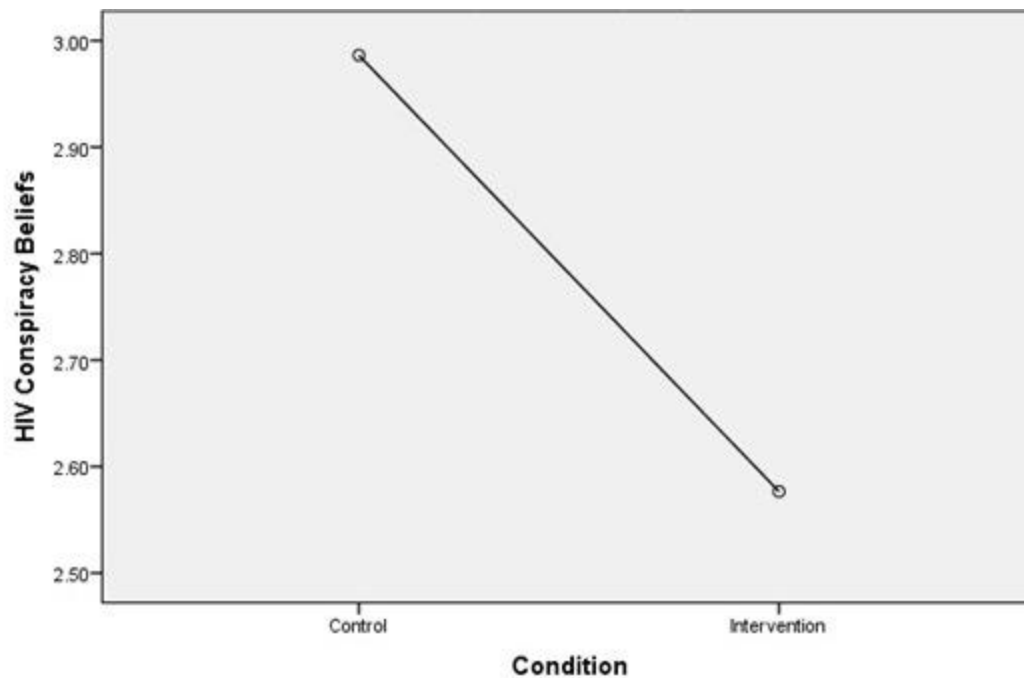


Figure 17. SISTA vs SITC: Follow-up HIV Conspiracy Beliefs

HIV knowledge. The ANCOVA assessing HIV knowledge had a statistically significant main effect, $F(1,161) = 9.095$, $p = .003$. Women in SISTA ($M = 5.24$, $SD = .88$) had significantly higher follow-up HIV knowledge scores than those in Safe in the City ($M = 4.81$, $SD = .87$) (see Figure 18).

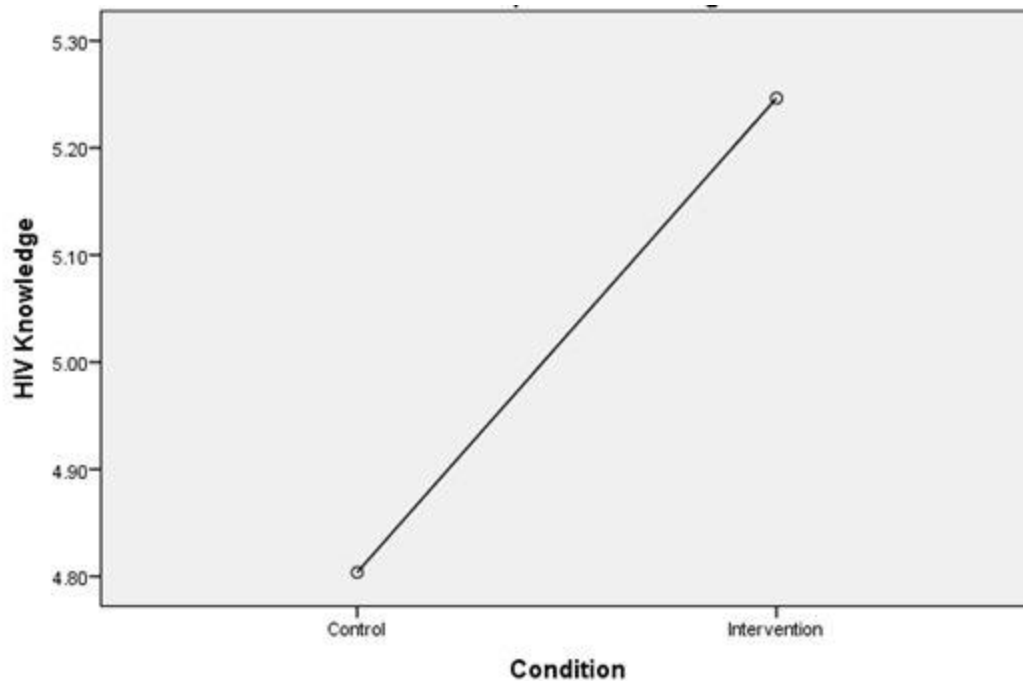


Figure 18. SISTA vs SITC: Follow-up HIV Knowledge

Sex and HIV testing outcomes. The ANCOVA examining the number of sexual partners had no statistically significant main effect, $F(1,161) = .127, p = .722$. There was no significant difference in number of partners between women in SISTA ($M = .91, SD = .76$) and those in Safe in the City ($M = .87, SD = .72$). Chi-square tests were computed to assess the relationship between condition and HIV testing and unprotected sex at follow-up. The relationship between condition (SISTA or Safe in the City) and unprotected oral sex was not significant, $X^2(1, N = 166) = 1.100, p = .294$. In addition, the relationship between condition and unprotected vaginal sex was not significant, $X^2(1, N = 167) = .056, p = .813$. Also, the relationship between condition (SISTA or Safe in the City) and HIV testing was not significant, $X^2(1, N = 189) = .640, p = .424$. As such, there was no significant difference in HIV testing or unprotected sex between SISTA and Safe in the City participants. Refer to Table 22 for descriptive information on the categorical sex outcomes.

Table 22.

Unprotected Sex and HIV Testing at Follow-up for SISTA and SITC Participants

| Variable | SISTA | | Safe in the City | |
|---------------------|--------|---------------|------------------|---------------|
| | Number | Valid Percent | Number | Valid Percent |
| Tested for HIV | 89 | 67.4% | 35 | 61.4% |
| Unprotected Oral | 106 | 91.4% | 43 | 86.0% |
| Unprotected Vaginal | 41 | 35.3% | 19 | 37.3% |

Drug outcomes. A series of ANCOVAs were performed to assess group differences in drug outcomes at follow-up. Refer to Table 23 for descriptive information. An ANCOVA was first performed to assess group differences in 30 day alcohol use. This analysis found that participants in Safe in the City ($M = 3.90$, $SD = 4.52$) had significantly greater 30 day alcohol use than SISTA participants ($M = 2.55$, $SD = 4.44$), $F(1, 158) = 4.013$, $p = .047$ (see Figure 18). An additional ANCOVA found a significant difference in the number of days SISTA and Safe in the City participants got drunk, $F(1, 159) = 6.099$, $p = .015$. Safe in the City participants ($M = 1.79$, $SD = 3.32$) had significantly more days of getting drunk than SISTA participants ($M = .88$, $SD = 1.79$) (see Figure 19). There was also no significant difference in 30 day marijuana between SISTA and Safe in the City participants, $F(1, 158) = .656$, $p = .419$.

Table 23.

Means and SDs for Drug Outcomes at Follow-up for SISTA and SITC

| Variable | SISTA | | SITC | |
|--------------|-------|------|------|------|
| | Mean | SD | Mean | SD |
| Past 30 Days | | | | |
| Alcohol | 2.55 | 4.36 | 3.90 | 4.52 |
| Drunk | .88 | 1.79 | 1.79 | 3.32 |
| Marijuana | 1.50 | 4.58 | 1.98 | 4.25 |

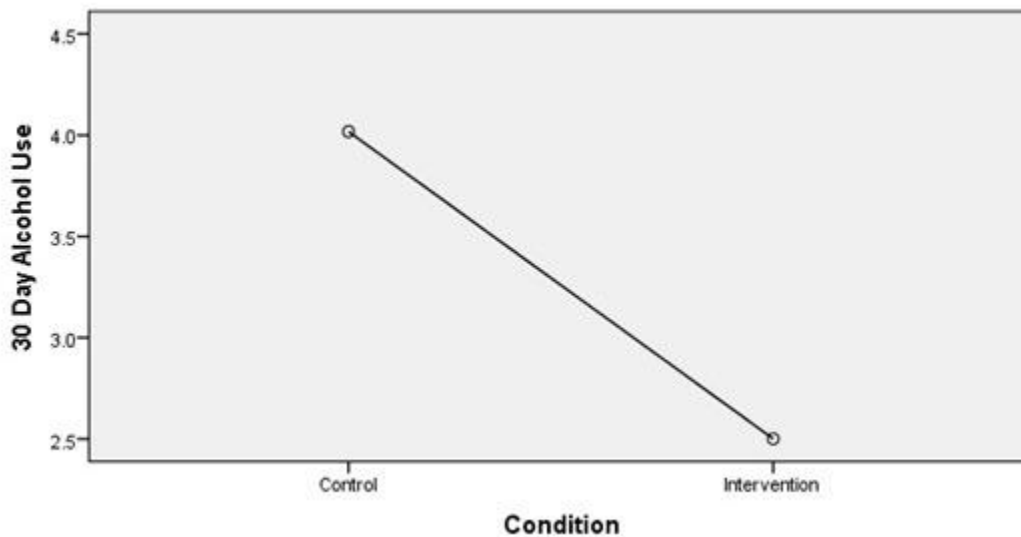


Figure 19. SISTA vs SITC: Follow-up 30 Day Alcohol Use

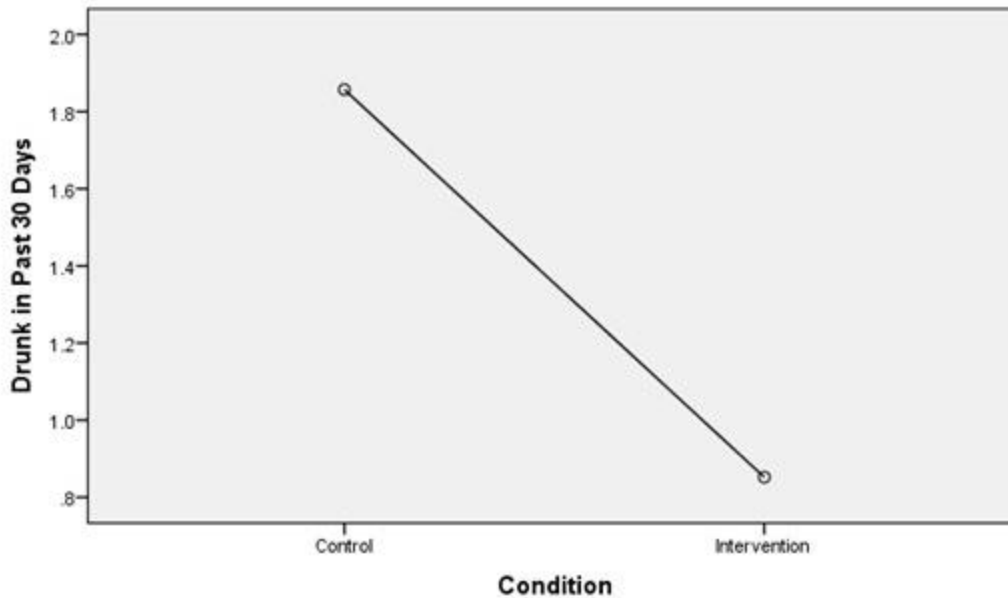


Figure 20. SISTA vs SITC: Follow-up Drunk in the Past 30 Days

Summary. There were a number of significant differences between women in SISTA and Safe in the City at follow-up. A series of ANCOVAs found that SISTA participants continued to have significantly greater levels of condom negotiation skills, condom use efficacy, and HIV knowledge at three month follow-up. However, there were no significant differences in unprotected vaginal sex at follow-up. Women in Safe in the City were significantly more likely to have more negative HIV testing attitudes and greater endorsement of HIV conspiracy beliefs. In addition, Safe in the City participants had significantly more 30 day alcohol use and a greater number of days in which they got drunk.

Question 10: Did Men Who Participated in Nia Have More Reduced HIV and Substance Use Risk Compared to Men in Safe in the City?

Nia vs SITC: Post-test comparisons. An additional series of ANOVAs were computed to compare outcomes between men in Nia and Safe in the City at post-test. Refer to Table 24 for descriptive information for Nia and Safe in the City at post-test.

Table 24.

Means and SDs for Outcome Measures at Post-test for Nia and SITC

| Variable | Nia | | Safe in the City | |
|--------------------|------|------|------------------|------|
| | Mean | SD | Mean | SD |
| Condom Attitudes | 2.03 | .41 | 1.75 | .40 |
| Condom Negotiation | 3.49 | .46 | 3.35 | .47 |
| Condom Efficacy | 2.86 | .18 | 2.71 | .34 |
| Testing Attitudes | 2.10 | 1.02 | 1.99 | .90 |
| Conspiracy Beliefs | 3.46 | .95 | 3.60 | .67 |
| HIV Knowledge | 4.97 | .83 | 4.42 | 1.02 |
| Number of Partners | 1.42 | 1.64 | 1.33 | .96 |

Condom attitudes. The ANOVA assessing differences in condom attitudes had a statistically significant main effect, $F(1,99) = 8.443$, $p = .005$. Men in Nia ($M = 2.03$, $SD = .41$) had significantly more negative condom attitudes than those in Safe in the City ($M = 1.75$, $SD = .40$) (see Figure 21).

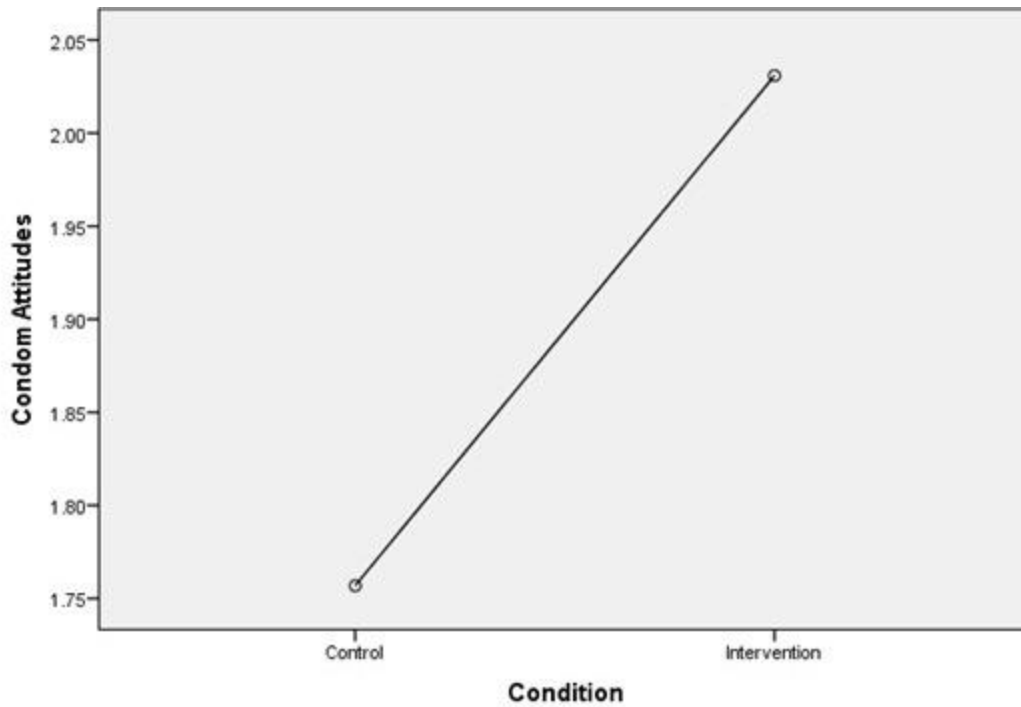


Figure 21. Nia vs SITC: Post-test Condom Attitudes

Condom efficacy. The ANOVA assessing differences in condom efficacy had a statistically significant main effect, $F(1,99) = 8.675$, $p = .004$. Men in Nia ($M = 2.86$, $SD = .18$) had significantly higher condom efficacy scores than those in Safe in the City ($M = 2.71$, $SD = .34$) (see Figure 22).

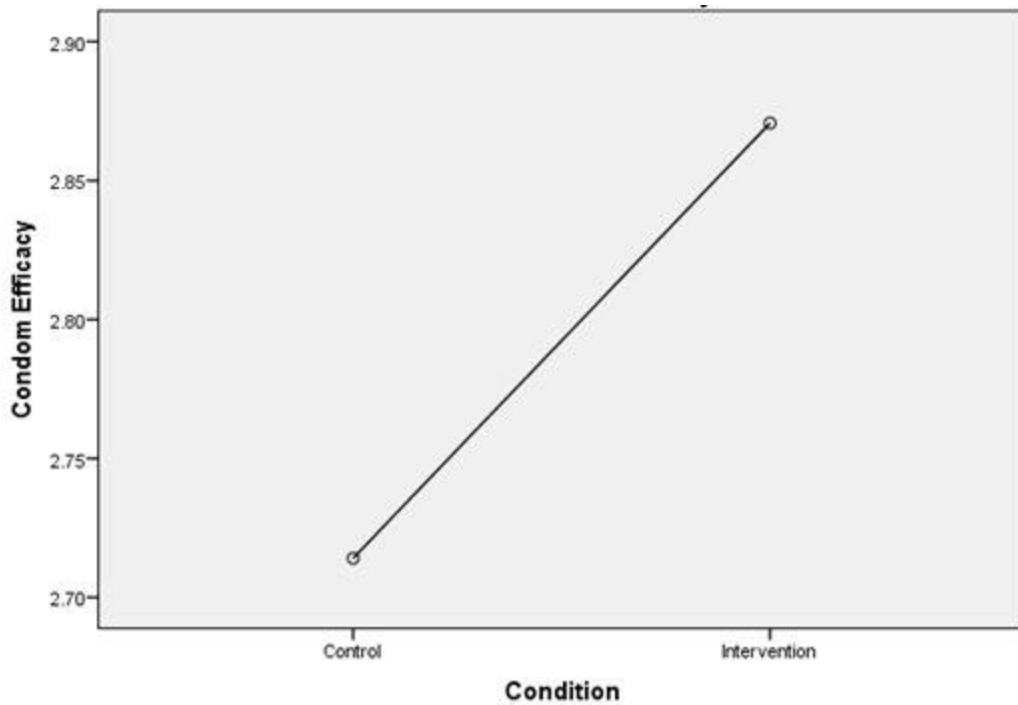


Figure 22. Nia vs SITC: Post-test Condom Efficacy

HIV knowledge. The ANOVA examining differences in HIV knowledge had a statistically significant main effect, $F(1,98) = 7.003, p = .009$. Men in Nia ($M = 4.97, SD = .83$) had significantly greater HIV knowledge scores at post-test than those in Safe in the City ($M = 4.42, SD = 1.02$).

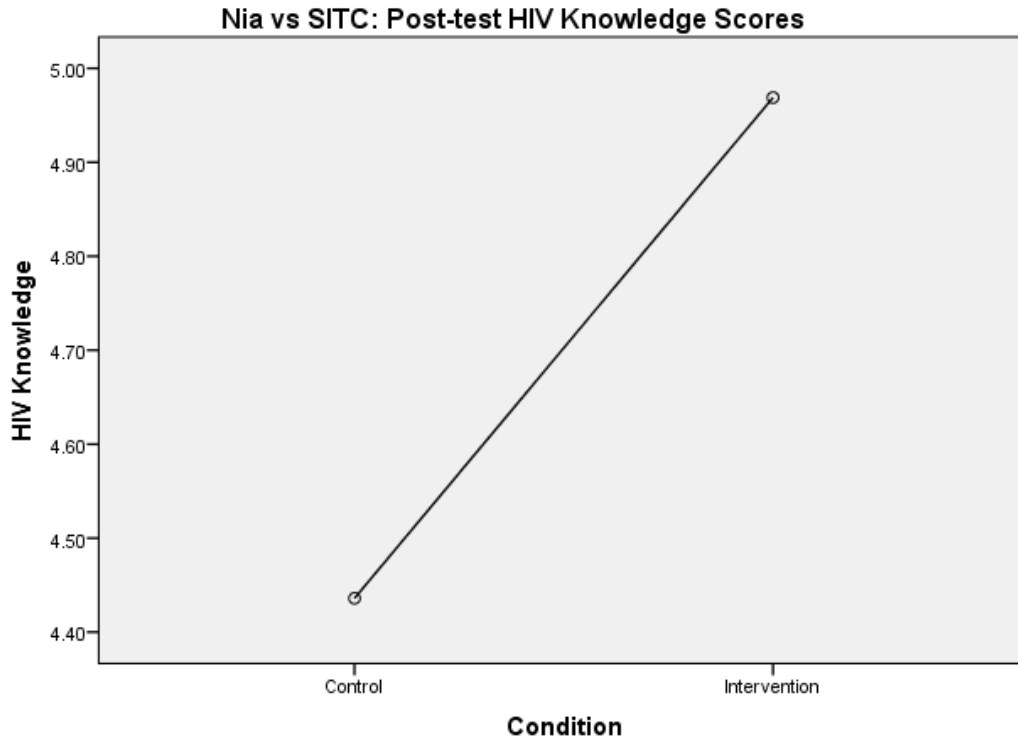


Figure 23. Nia vs SITC: Post-test HIV Knowledge Scores

Additional outcomes. There were no significant differences between men in Nia and Safe in the City on the other outcome variables. A series of ANOVAs found no significant difference in post-test 1) condom negotiation, $F(1,99) = 1.960, p = .165$, 2) HIV testing attitudes, $F(1,98) = .173, p = .679$, and 3) HIV conspiracy beliefs, $F(1,99) = .472, p = .494$.

Sex and HIV testing outcomes. An ANOVA indicated there was no significant difference in the number of partners at post-test between men in Nia ($M = 1.42, SD = 1.64$) and those in Safe in the City ($M = 1.33, SD = .96$), $F(1,94) = .053, p = .818$. Chi-square tests were computed to assess the relationship between condition and HIV testing and unprotected sex. The relationship between condition (Nia or Safe in the City) and unprotected oral sex was not significant, $X^2(1, N = 99) = .729, p = .393$. The relationship between condition (Nia or Safe in

the City) and unprotected oral sex was not significant, $X^2(1, N = 80) = .098, p = .754$. Also, the relationship between condition and unprotected vaginal sex was not significant, $X^2(1, N = 85) = .354, p = .552$. As such, there were no significant differences in HIV testing or unprotected sex at post-test between Nia and Safe in the City participants. Refer to Table 25 for descriptive information on post-test sex outcomes.

Table 25.

Unprotected Sex and HIV Testing at Post-test for Nia and SITC Participants

| Variable | Nia | | Safe in the City | |
|---------------------|--------|---------------|------------------|---------------|
| | Number | Valid Percent | Number | Valid Percent |
| Tested for HIV | 35 | 47.9% | 15 | 57.7% |
| Unprotected Oral | 56 | 91.8% | 17 | 89.5% |
| Unprotected Vaginal | 21 | 30.9% | 4 | 23.5% |

Drug outcomes. A series of ANOVAs were conducted to assess drug use outcomes between Nia and Safe in the City participants. Refer to Table 26 for descriptive information on drug outcomes. The first analysis found no statistically significant difference in 30 day alcohol use at post-test between men in Nia ($M = 2.18, SD = 6.17$) and Safe in the City ($M = 2.33, SD = 5.76$), $F(1, 91) = .007, p = .934$. There was no significant difference between Nia ($M = 5.21, SD = 5.72$) and Safe in the City participants ($M = 5.86, SD = 6.23$) on the number of days drunk, $F(1, 89) = .214, p = .645$. There was also no significant difference in 30 day marijuana between Nia ($M = 3.26, SD = 5.92$) and Safe in the City participants ($M = 4.00, SD = 6.71$), $F(1, 87) = .278, p = .599$.

Table 26.

Means and SDs for Drug Outcomes at Post-test for Nia and SITC

| Variable | Nia | | SITC | |
|---------------|------|------|------|------|
| | Mean | SD | Mean | SD |
| Past 30 Days | | | | |
| Alcohol Use | 2.18 | 6.17 | 2.33 | 5.76 |
| Got Drunk | 5.21 | 5.72 | 5.86 | 6.23 |
| Marijuana Use | 3.26 | 5.92 | 4.00 | 6.71 |

Summary. The post-test findings indicated that men who participated in Nia had significantly greater condom efficacy and HIV knowledge than men who participated in Safe in the City. Men in Nia also had significantly more negative condom attitudes. No other significant differences were found between Nia and Safe in the City participants.

Nia vs SITC: Follow-up comparisons. An additional series of ANOVAs were computed to compare outcomes between men in Nia and Safe in the City at follow-up. Refer to Table 27 for descriptive information for follow-up outcomes.

Table 27.

Means and SDs for Outcome Measures at Follow-up for Nia and SITC

| Variable | Nia | | Safe in the City | |
|--------------------|------|------|------------------|------|
| | Mean | SD | Mean | SD |
| Condom Attitudes | 2.08 | .55 | 1.82 | .38 |
| Condom Negotiation | 3.54 | .39 | 3.57 | .39 |
| Condom Efficacy | 2.86 | .23 | 2.81 | .30 |
| Testing Attitudes | 2.14 | 1.05 | 1.94 | .91 |
| Conspiracy Beliefs | 3.44 | 1.07 | 3.80 | .72 |
| HIV Knowledge | 4.66 | 1.29 | 4.30 | 1.22 |
| Number of Partners | 1.54 | 2.47 | 1.00 | .90 |

Condom attitudes. The ANOVA for condom attitudes at follow-up was statistically significant, $F(1,91) = 4.279$, $p = .041$, and men in Nia ($M = 2.08$, $SD = .55$) had significantly more negative condom attitudes than those in Safe in the City ($M = 1.82$, $SD = .38$) (see Figure 23).

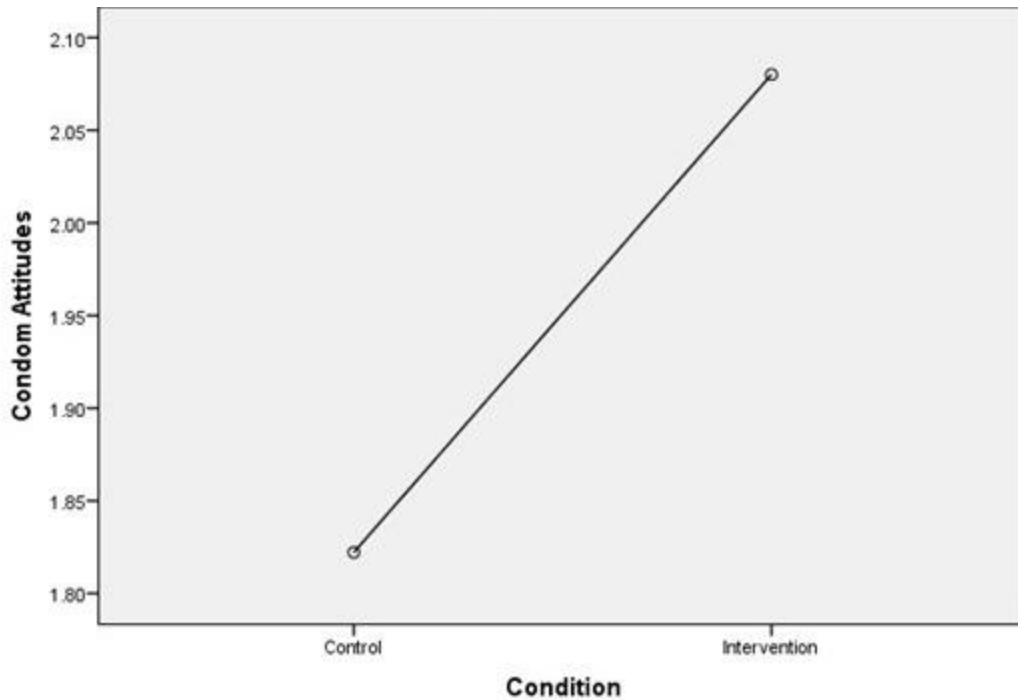


Figure 24. Nia vs SITC: Follow-up Condom Attitudes

Additional outcomes. Analyses for the additional outcome variables indicated no significant differences between Nia and Safe in the City. A series of ANOVAs found no significant difference in follow-up 1) *condom attitudes*, $F(1,91) = .126, p = .723$, 2) *condom efficacy*, $F(1,91) = .796, p = .375$, 3) *HIV testing attitudes*, $F(1,91) = .636, p = .427$, 4) *HIV conspiracy beliefs*, $F(1,90) = 2.259, p = .136$, and 5) *HIV knowledge*, $F(1,86) = 1.302, p = .257$.

Sex and HIV testing outcomes. An ANOVA found no significant difference in the number of sexual partners between men in Nia ($M = 1.54, SD = 2.47$) and those in Safe in the City ($M = 1.00, SD = .90$), $F(1,85) = 1.104, p = .296$. Chi-square tests were computed to assess the relationship between condition and HIV testing and unprotected sex. The relationship between condition (Nia or Safe in the City) and unprotected oral sex was not significant, $X^2(1, N = 76) = 2.754, p = .097$. Also, the relationship between condition and unprotected vaginal sex

was not significant, $X^2 (1, N = 83) = 2.125, p = .145$. As such, there were no significant differences in HIV testing or unprotected sex between Nia and Safe in the City participants at follow-up. Refer to 28 for descriptive information on the categorical sex outcomes.

Table 28.

Unprotected Sex and HIV Testing at Follow-up for Nia and SITC Participants

| Variable | Nia | | Safe in the City | |
|---------------------|--------|---------------|------------------|---------------|
| | Number | Valid Percent | Number | Valid Percent |
| Tested for HIV | 30 | 46.9% | 13 | 56.5% |
| Unprotected Oral | 49 | 87.5% | 20 | 100.0% |
| Unprotected Vaginal | 20 | 31.7% | 3 | 15.0% |

Drug outcomes. A series of ANOVAs were conducted to assess differences in drug outcomes at follow-up. Refer to Table 29 for descriptive information on outcomes. There was no statistically significant difference in 30 day alcohol use between men in Nia ($M = 4.94, SD = 5.17$) and Safe in the City ($M = 4.17, SD = 5.37$), $F(1, 91) = .426, p = .515$. An additional ANCOVA found no significant difference in the number of days participants got drunk between Nia ($M = 3.12, SD = 4.42$) and Safe in the City ($M = 2.17, SD = 4.18$), $F(1, 89) = .819, p = .368$. There was also no significant difference in 30 day marijuana use between Nia ($M = 5.63, SD = 10.18$) and Safe in the City participants ($M = 2.57, SD = 5.50$), $F(1, 87) = 1.859, p = .176$.

Table 29.

Means and SDs for Drug Outcomes at Follow-up for SISTA and SITC

| Variable | Nia | | SITC | |
|---------------|------|-------|------|------|
| | Mean | SD | Mean | SD |
| Past 30 Days | | | | |
| Alcohol Use | 4.94 | 5.17 | 4.17 | 5.37 |
| Got Drunk | 3.12 | 4.42 | 2.17 | 4.18 |
| Marijuana Use | 5.63 | 10.18 | 2.57 | 5.50 |

Summary. The follow-up findings indicated few differences between men who participated in Nia and Safe in the City. The only significant finding was that men in Nia continued to have more negative condom attitudes. No other significant differences were found between Nia and Safe in the City participants.

Question 11: Did Women Who Participated in Enhanced SISTA Have Reduced HIV and Substance Use Risk Compared to the Women in Standard SISTA?

Standard SISTA vs Enhanced SISTA: Post-test comparisons. An additional series of ANOVAs were computed to compare outcomes between women in Standard SISTA and Enhanced SISTA at post-test. Refer to Table 30 for descriptive information on outcome measures. An ANOVA was performed to assess group differences in condom attitudes. There was no statistically significant difference in post-test condom attitudes between Standard SISTA ($M = 1.50$, $SD = .38$) and Enhanced SISTA ($M = 1.51$, $SD = .47$), $F(1, 130) = .029$, $p = .865$. An ANOVA found no significant difference in post-test condom negotiation scores between

Standard SISTA ($M = 3.69$, $SD = .31$) and Enhanced SISTA ($M = 3.65$, $SD = .30$), $F(1, 130) = .582$, $p = .447$. Also, there was no statistically significant difference in condom efficacy between Standard SISTA ($M = 2.80$, $SD = .24$) and Enhanced SISTA ($M = 2.82$, $SD = .30$), $F(1, 130) = .252$, $p = .617$. An ANOVA also assessed group differences in HIV testing attitudes. There was no statistically significant difference in post-test testing attitudes between Standard SISTA ($M = 1.78$, $SD = .79$) and Enhanced SISTA ($M = 1.60$, $SD = .72$), $F(1, 130) = 1.908$, $p = .170$. An ANOVA found no statistically significant difference in post-test conspiracy beliefs between Standard SISTA ($M = 2.63$, $SD = .92$) and Enhanced SISTA ($M = 2.40$, $SD = .90$), $F(1, 130) = 2.177$, $p = .142$. Finally, there was no significant difference in post-test HIV knowledge between Standard SISTA ($M = 5.27$, $SD = .96$) and Enhanced SISTA ($M = 5.36$, $SD = .84$), $F(1, 130) = .395$, $p = .531$.

Table 30.

Means and SDs for Outcome Measures at Post-test for Standard SISTA and Enhanced SISTA

| Variable | Standard | | Enhanced | |
|--------------------|----------|-----|----------|-----|
| | Mean | SD | Mean | SD |
| Condom Attitudes | 1.50 | .38 | 1.51 | .47 |
| Condom Negotiation | 3.69 | .31 | 3.65 | .30 |
| Condom Efficacy | 2.80 | .24 | 2.82 | .30 |
| Testing Attitudes | 1.78 | .79 | 1.60 | .72 |
| Conspiracy Beliefs | 2.63 | .92 | 2.40 | .90 |
| HIV Knowledge | 5.27 | .96 | 5.36 | .84 |
| Number of Partners | .90 | .73 | .98 | .81 |

Sex and HIV testing outcomes. The ANOVA assessing differences in number of partners had no statistically significant main effect, $F(1,85) = 1.104, p = .296$. There was no significant difference in the number of partners between Standard SISTA ($M = .90, SD = .73$) and Enhanced SISTA ($M = .98, SD = .81$). Chi-square tests were computed to assess the relationship between condition and HIV testing and unprotected sex. The relationship between condition (Standard or Enhanced SISTA) and HIV testing was not significant, $X^2(1, N = 131) = .900, p = .343$. The relationship between condition (Standard or Enhanced SISTA) and unprotected oral sex was not significant, $X^2(1, N = 116) = 2.581, p = .108$. Also, the relationship between condition and unprotected vaginal sex was not significant, $X^2(1, N = 105) = .793, p = .373$. As such, there were no significant differences in oral or vaginal sex at post-test between Standard or Enhanced SISTA participants. See Table 31 for descriptive information on categorical sex outcomes.

Table 31.

Unprotected Sex and HIV Testing at Post-test for Standard and Enhanced SISTA Participants

| Variable | Standard | | Enhanced | |
|---------------------|----------|---------------|----------|---------------|
| | Number | Valid Percent | Number | Valid Percent |
| Tested for HIV | 35 | 60.3% | 38 | 52.1% |
| Unprotected Oral | 44 | 84.6% | 60 | 93.8% |
| Unprotected Vaginal | 16 | 32.7% | 23 | 41.1% |

Drug outcomes. A series of ANOVAs were performed to assess significant differences in drug outcomes between Standard and Enhanced SISTA. The first analysis indicated a statistically significant difference in 30 alcohol use between Standard and Enhanced SISTA, $F(1,$

129) = 5.976, $p = .016$. Women in Enhanced SISTA ($M = 3.00$, $SD = 4.22$) had significantly more 30 day alcohol use than women in Standard SISTA ($M = 1.53$, $SD = 1.94$). An additional ANOVA found no significant difference in the number of days participants got drunk between Standard SISTA ($M = .88$, $SD = 2.01$) and Enhanced SISTA ($M = 1.75$, $SD = 3.49$), $F(1, 128) = 2.829$, $p = .095$. There was also no significant difference in 30 day marijuana use between Standard SISTA ($M = 1.19$, $SD = 4.38$) and Enhanced SISTA participants ($M = 1.49$, $SD = 4.30$), $F(1, 128) = .150$, $p = .699$. Refer to Table 32 for descriptive information on categorical drug outcomes.

Table 32.

Means and SDs for Drug Outcomes at Post-test for Standard SISTA and Enhanced SISTA

| Variable | Standard | | Enhanced | |
|---------------|----------|------|----------|------|
| | Mean | SD | Mean | SD |
| Past 30 Days | | | | |
| Alcohol Use | 1.53 | 1.94 | 3.00 | 4.22 |
| Got Drunk | .88 | 2.01 | 1.75 | 3.49 |
| Marijuana Use | 1.19 | 4.38 | 1.49 | 4.30 |

Summary. There were few post-test differences between women in Standard SISTA and Enhanced SISTA. The only significant finding was that women in Enhanced SISTA had greater 30 day alcohol use than women in the standard version of the intervention. No other significant differences were found between Standard and Enhanced SISTA.

Standard SISTA vs Enhanced: Follow-up comparisons. A series of ANOVAs were computed to compare outcomes between women in Standard SISTA and Enhanced SISTA at follow-up. Refer to Table 33 for descriptive information. There was no statistically significant difference in follow-up condom attitudes between Regular SISTA ($M = 1.72$, $SD = .58$) and Enhanced SISTA ($M = 1.65$, $SD = .55$), $F(1, 129) = .478$, $p = .490$. There was no statistically significant difference in follow-up condom negotiation scores between Standard SISTA ($M = 3.75$, $SD = .31$) and Enhanced SISTA ($M = 3.72$, $SD = .32$), $F(1, 130) = .294$, $p = .589$. An ANOVA found no statistically significant difference in condom efficacy between Standard SISTA ($M = 2.82$, $SD = .28$) and Enhanced SISTA ($M = 2.78$, $SD = .33$), $F(1, 130) = .619$, $p = .433$. An ANOVA was performed to assess group differences in HIV testing attitudes. There was no statistically significant difference in follow-up testing attitudes between Standard SISTA ($M = 1.54$, $SD = .64$) and Enhanced SISTA ($M = 1.58$, $SD = .78$), $F(1, 129) = .091$, $p = .763$. An ANOVA found no statistically significant difference in follow-up conspiracy beliefs between Standard SISTA ($M = 2.58$, $SD = 1.03$) and Enhanced SISTA ($M = 2.62$, $SD = .95$), $F(1, 129) = .065$, $p = .800$. An ANOVA assessed group differences in HIV knowledge and found no statistically significant difference between Standard SISTA ($M = 5.33$, $SD = .74$) and Enhanced SISTA ($M = 5.14$, $SD = .98$), $F(1, 130) = 1.511$, $p = .221$.

Table 33.

Means and SDs for Outcome Measures at Follow-up for Standard SISTA and Enhanced SISTA

| Variable | Standard | | Enhanced | |
|--------------------|----------|------|----------|-----|
| | Mean | SD | Mean | SD |
| Condom Attitudes | 1.72 | .58 | 1.65 | .55 |
| Condom Negotiation | 3.75 | .31 | 3.72 | .32 |
| Condom Efficacy | 2.82 | .28 | 2.78 | .33 |
| Testing Attitudes | 1.54 | .64 | 1.58 | .78 |
| Conspiracy Beliefs | 2.58 | 1.03 | 2.62 | .95 |
| HIV Knowledge | 5.33 | .74 | 5.14 | .98 |
| Number of Partners | .90 | .81 | .87 | .68 |

Sex and HIV outcomes. An ANOVA found no statistically significant difference in number of sexual partners between Standard SISTA ($M = .90$, $SD = .81$) and those in Enhanced SISTA ($M = .87$, $SD = .68$), $F(1,130) = .072$, $p = .788$. Chi-square tests were computed to assess the relationship between condition and HIV testing and unprotected sex. The relationship between condition (Standard or Enhanced SISTA) and HIV testing was not significant, $X^2(1, N = 132) = .880$, $p = .348$. The relationship between condition (Standard or Enhanced SISTA) and unprotected oral sex was not significant, $X^2(1, N = 116) = .300$, $p = .584$. Also, the relationship between condition and unprotected vaginal sex was not significant, $X^2(1, N = 116) = .220$, $p = .639$. As such, there were no significant differences in HIV testing or unprotected sex at follow-up between Standard or Enhanced SISTA participants. See Table 34 for descriptive information on sex outcomes and HIV testing.

Table 34.

Unprotected Sex and HIV Testing at Follow-up for SISTA and Nia Participants

| Variable | Standard | | Enhanced | |
|---------------------|----------|---------------|----------|---------------|
| | Number | Valid Percent | Number | Valid Percent |
| Tested for HIV | 45 | 71.4% | 44 | 63.8% |
| Unprotected Oral | 52 | 92.9% | 54 | 90.0% |
| Unprotected Vaginal | 21 | 37.5% | 20 | 33.3% |

Drug outcomes. A series of ANOVAs were conducted to assess differences in drug outcomes. Refer to Table 35 for descriptive information. The first ANOVA assessed group differences in 30 day alcohol use at follow-up. There was a statistically significant difference between Standard and Enhanced SISTA, $F(1, 130) = 5.347, p = .022$. Women in Enhanced SISTA ($M = 3.41, SD = 5.45$) had significantly more 30 day alcohol use than women in Standard SISTA ($M = 1.70, SD = 2.24$). An additional ANOVA was used to assess differences in the number of days participants got drunk. There was no significant difference in the number of days participants in Standard SISTA ($M = .83, SD = 1.73$) and Enhanced SISTA ($M = 1.17, SD = 2.73$) got drunk, $F(1, 130) = .746, p = .389$. There was also no significant difference in 30 day marijuana use between Standard SISTA ($M = 1.08, SD = 4.27$) and Enhanced SISTA participants ($M = 1.60, SD = 4.26$), $F(1, 128) = .486, p = .487$.

Table 35.

Means and SDs for Drug Outcomes at Follow-up for Standard SISTA and Enhanced SISTA

| Variable | Standard | | Enhanced | |
|---------------|----------|------|----------|------|
| | Mean | SD | Mean | SD |
| Past 30 Days | | | | |
| Alcohol Use | 1.70 | 2.24 | 3.41 | 5.45 |
| Got Drunk | .83 | 1.73 | 1.17 | 2.73 |
| Marijuana Use | 1.08 | 4.27 | 1.60 | 4.26 |

Summary. As with post-test differences, there were few differences between women in Standard SISTA and Enhanced SISTA at follow-up. Women in Enhanced SISTA continued to have significantly greater 30 day alcohol use than women who participated in the standard version of the intervention. No other significant differences were found between Standard and Enhanced SISTA.

Question 12: Did African American College Students Demonstrate Reduced HIV and Substance Use Risk?

In order to assess the impact of peer education events and the social marketing campaign, data from the American College Health Association's (ACHA) National College Health Assessment were examined. Drug use and sexual risk items were assessed in the years 2010 and 2014. There were 230 African American students in the 2010 NCHA sample. The average age of students was 23.44 years. The 2010 sample was 81.3% (n = 187) female and 18.7% (n = male). The 2014 sample contained 150 African American students and the average age was

21.83 years. An independent samples t-test was computed to assess if there were any significant demographic differences in the NCHA samples from 2010 to 2014. The 2014 sample ($M = 21.83$, $SD = 4.42$) was significantly younger than the 2010 sample ($M = 23.44$, $SD = 6.16$). As such, age was controlled for in subsequent ANCOVAs. The sample was 74.8% ($n = 113$) female and 24.7% ($n = 37$). The average age of the combined sample was 22.80 years. The combined sample was 78.9% ($n = 300$) female and 21.1% ($n = 80$) male. The following sexual behavior items were compared in 2010 and 2014:

- Within the last 12 months, with how many partners have you had oral sex, vaginal intercourse, or anal intercourse?
- Within the last thirty days, how often did you or your partner(s) use a condom or other protective barrier (e.g., male condom, female condom, dam, glove) during oral sex?
- Within the last thirty days, how often did you or your partner(s) use a condom or other protective barrier (e.g., male condom, female condom, dam, glove) during oral sex?
- Within the last 12 months, have you had unprotected sex when drinking alcohol?

The following drug use items were assessed:

- The last time you “partied”/socialized how many drinks of alcohol did you have?
- The last time you “partied”/socialized, over how many hours did you drink alcohol?
- Over the last two weeks, how many times have you had five or more drinks of alcohol at a sitting?

Sexual risk outcomes. Refer to Table 36 for descriptive information on outcomes. A series of ANCOVAs were computed to assess differences in sexual risk outcomes among students in 2010 and 2014. There was no significant difference in number of partners between 2010 ($M = 1.51$, $SD = 2.39$) and 2014 ($M = 1.39$, $SD = 1.90$). There was no significant

difference in unprotected oral sex between 2010 ($M = 2.40$, $SD = 1.18$) and 2014 ($M = 2.50$, $SD = 1.41$). In addition, there was no difference in unprotected vaginal sex in 2010 ($M = 3.52$, $SD = 2.20$) and 2014 ($M = 3.53$, $SD = 2.30$). A chi square test was performed to assess if there was a significant difference in having unprotected sex due to alcohol between 2010 and 2014. There was no relationship between year and having unprotected sex due to alcohol ($1, N = 276$) = .955, $p = .328$.

Table 36.

Sexual Risk Outcomes for African American College Students

| Outcome | Year | | | |
|-------------------------|------|------|------|------|
| | 2010 | | 2014 | |
| | Mean | SD | Mean | SD |
| Number of Partners | 1.51 | 2.39 | 1.39 | 1.90 |
| Oral Sex Unprotected | 2.40 | 1.18 | 2.50 | 1.41 |
| Vaginal Sex Unprotected | 3.52 | 2.20 | 3.53 | 2.30 |

Drug use outcomes. Refer to Table 37 for descriptive information. There was a marginally significant difference in the mean number of drinks participants had in 2010 ($M = 2.03$, $SD = 2.50$) and 2014 ($M = 2.56$, $SD = 2.61$), $F(1, 372) = 3.00$, $p = .084$ and students in 2014 reported drinking slightly more than those in 2010. There was no significant difference in the number of hours participants drank in 2010 ($M = 1.93$, $SD = 2.45$) and 2014 ($M = 2.05$, $SD = 1.89$), $F(1, 371) = .337$, $p = .562$. There was no significant difference in the number of times students had five or more drinks in 2010 ($M = 2.07$, $SD = 1.37$) and 2014 ($M = 2.30$, $SD = 1.15$), $F(1, 372) = .295$, $p = .131$.

Table 37.

Alcohol Use for African American College Students in 2010 and 2014

| Outcome | Year | | | |
|-----------------------|------|------|------|------|
| | 2010 | | 2014 | |
| | Mean | SD | Mean | SD |
| Mean Number of Drinks | 2.02 | 2.50 | 2.57 | 2.61 |
| Hours Spent Drinking | 1.92 | 2.45 | 2.04 | 1.88 |
| Five or more drinks | 2.07 | 1.37 | 2.30 | 1.16 |

Summary. A series of ANCOVAs and a chi-square test were performed to assess differences among African American students in the years 2010 and 2014. The findings indicated there were no statistically significant differences in sexual and drug use outcomes for these years.

Summary of Findings from Outcome Evaluation

This outcome evaluation was designed to assess the effectiveness of the Raise 5 Project's evidence based interventions. The first outcome evaluation questioned assessed if the project had an adequate retention rate. The project's follow-up retention rate was 87% for participants across the three evidence based interventions: SISTA, Nia, and Safe in the City. While the evaluation literature is mixed in regard to what is an acceptable retention rate, research suggests that having an 80% or higher retention rate is sufficient (Fisher et al., 2001)

The second question examined if participants across all interventions demonstrated reduced HIV and substance use risk. The findings suggested that SISTA and Nia were effective at reducing negative condom attitudes, but the reductions could not be maintained at three month follow-up. However, participation in these interventions led to statistically significant increases in condom negotiation, condom efficacy, and HIV knowledge from pre-test to post-test. These increases were also maintained at follow-up. Participation in SISTA and Nia also led to statistically significant decreases in negative HIV testing attitudes and conspiracy beliefs from pre-test to post-test. These decreases were also maintained at follow-up. Safe in the City did not produce as many positive findings. While Safe in the City participants had a significant decrease in their number of sexual partners, they also had an increase in negative condom attitudes.

The third outcome evaluation question determined if SISTA participants had reduced HIV and substance use risk compared to those in Safe in the City. There were a number of significant differences between women in SISTA and Safe in the City at post-test. SISTA participants had significantly greater levels of condom negotiation skills, condom use efficacy, and HIV knowledge after their intervention concluded. In addition, women in SISTA were significantly more likely to engage in protected vaginal sex. Women in Safe in the City also demonstrated a significantly greater endorsement of HIV conspiracy beliefs.

At follow-up, SISTA participants continued to have significantly greater levels of condom negotiation skills, condom efficacy, and HIV knowledge. However, there were no significant differences in unprotected vaginal sex. Safe in the City participants were significantly more likely to have more negative HIV testing attitudes and greater endorsement of HIV conspiracy beliefs. In addition, Safe in the City participants also had significantly more 30 day alcohol use and a greater number of days in which they got drunk.

The fourth outcome evaluation question examined if Nia participants had reduced HIV and substance use risk compared to those in Safe in the City. At post-test, men who participated in Nia had significantly greater condom efficacy and HIV knowledge than men who participated in Safe in the City. However, men in Nia also had significantly more negative condom attitudes at post-test and follow-up.

The fifth question assessed if women in Standard SISTA had reduced HIV and substance use risk compared to those in Enhanced SISTA. There were few post-test differences between women in Standard SISTA and Enhanced SISTA. The only significant finding was that women in Enhanced SISTA had greater 30 day alcohol use than women in the standard version of the intervention. At follow-up, women in Enhanced SISTA continued to have significantly greater 30 day alcohol use than women in the standard version of the intervention. No other significant differences were found between Standard and Enhanced SISTA.

The final outcome evaluation question sought to determine if African American students demonstrated reduced HIV and substance use risk. Utilizing data from the National College Health Survey, a series of comparisons were made of sexual and drug behavior for the years 2010 and 2014. The findings indicated there were no statistically significant differences in sexual and drug use outcomes for these years.

Discussion

This dissertation is an evaluation of the Raise 5 Project, which was designed to provide comprehensive HIV and substance abuse prevention services to African American students at VCU. This dissertation assessed process and outcome evaluation results for the Raise 5 Project's four strategies: 1) evidence based interventions, 2) peer education and awareness

events, 3) HIV testing and counseling, and 4) a social marketing campaign. Twelve questions were developed to guide this evaluation study. The first six questions were developed to structure the process evaluation, while the latter six focused on the outcome evaluation.

Summary of the Process Evaluation

The first evaluation question assessed whether the evidence based interventions were delivered with fidelity. Systematic observations and facilitator interviews suggest that the implementation of SISTA and Nia closely followed the core elements of both interventions. The appropriate facilitators were used and all sessions were delivered in a small group format. Also, participants were provided information on HIV, condom use, and other safe sex practices. However, some adaptations to intervention delivery were made. The most common change was the time length of session activities. The training materials specify a particular amount of time to be spent on each intervention activity. However, circumstances did not always permit these time guidelines to be followed. For example, if participants arrived to sessions late, certain activities had to be condensed or delayed until later sessions. More substantive changes were made in the implementation of Nia. Although described in the training materials, an initial intake session was not conducted. In addition, a Pre-Intervention Assessment Survey and a series of Personal Feedback Report (PFR) forms were not utilized in the sessions. Despite these changes, the project delivered SISTA and Nia in a way that adhered to each intervention's core elements.

The second evaluation question examined whether the facilitators experienced any complications when delivering the interventions. Systematic observations conducted by experienced SISTA facilitators indicated that some facilitators tended to "overshare" personal information or embarrassing stories during sessions. While this may have increased rapport between facilitators and participants, it may have also compromised the facilitator's credibility as

a source of knowledge. As such, facilitators were encouraged to keep “oversharing” to a minimum. While SISTA was well-regarded by most participants, facilitators noted that a few individuals did not seem engaged by the intervention. These inattentive participants often identified as lesbian or bisexual, suggesting that sexual orientation may have played a role in the relevancy of the intervention. These experiences seem to have informed one facilitator’s belief that SISTA is most relevant for women that have sex with men. Despite these challenges, the findings of the outcome evaluation suggest that SISTA was a highly effective intervention. The participants benefitted in a number of ways, including increases in HIV knowledge and safer sex behaviors. The women also demonstrated a strong commitment to the program, indicated by SISTA’s high retention rate.

Interviews with two Nia facilitators suggested that implementation was affected by different challenges. The most serious challenge was related to recruitment bias. Bias refers to the degree to which some subgroups participate in a program more than others (Rossi, Lipsey, & Freeman, 2004). While project staff had few problems recruiting African American women for SISTA, they often struggled with recruiting African American men for Nia. Some staff members noted that some men would sign up for Nia but not attend any sessions. It was estimated that for every ten men recruited, about five to seven actually attended Nia sessions. In a few cases, Nia cohorts began with as few as three participants. Recruitment would be continued through the second week to add more participants for the remaining sessions. The recruitment challenges are demonstrated by the fact that only 85 men participated in Nia, while 143 women participated in SISTA. These recruitment issues contributed to other challenges, as Nia facilitators reported that effective group discussion were more difficult in smaller groups. As such, the primary female Nia facilitator reported feeling that Nia was not implemented as designed.

There are several potential reasons for why there was differential recruitment for males and females. One reason may be that women are more relational. As a result, they may have been more enthusiastic about the opportunity to engage in group discussions and activities with other women. Another reason may be due to differences in the intervention's core elements. SISTA was designed to increase HIV knowledge and safer sex behaviors, while also promoting gender and ethnic pride. Nia did not have this cultural focus, which may have created the perception that Nia was solely an educational program. This may have made Nia seem less appealing and contributed to some men's decision not to participate.

The third evaluation question assessed how the interventions were perceived by participants. This question was assessed using participant feedback forms completed after each session. Participants rated how much they enjoyed the session and their facilitators. Participants could also provide personalized feedback in a comments section on the survey. Here, participants in both interventions reported having increased HIV knowledge, condom use, and condom efficacy. This was supported by the findings of the outcome evaluation which found statistically significant increases in HIV knowledge and condom efficacy. Also, there were marginally significant reductions in the percentage of participants who engaged in unprotected oral and vaginal sex. Many SISTA and Nia participants reported using the information they learned, such as limiting the amount of alcohol they drank at parties or making sure they had condoms available in any situation. While participants self-reported changes in alcohol use, the outcome evaluation did not detect any statistically significant decreases in alcohol use among SISTA or Nia participants.

One of the SISTA facilitators who previously participated in the intervention reported being more in control of her body and confident in her ability to protect herself after participating

in SISTA. This facilitator reported that several participants expressed similar feelings after completing the intervention. SISTA also seemed to generate a greater sense of gender and ethnic pride among participants. More specifically, many participants demonstrated increased assertiveness in their personal lives. In addition to negotiating condom use with their partners, they were able to effectively handle other situations, such as leaving unhealthy or abusive relationships. Also, several participants reported enjoying the opportunity to interact and bond with other African American women and they also praised their facilitators as positive role models. Nia participants did not provide similar feedback, which may be due to the differences in the interventions. Nia did not attempt to increase gender and ethnic pride, as it was more focused on increasing HIV knowledge.

The fourth question assessed whether the target population attended the peer education events. Data were available for five out of the eight edutainment events and indicated that the project was able to successfully reach its target population. African American students were the largest racial/ethnic group in attendance at each event, with percentages ranging from 64% - 89%. These findings indicate that the Raise 5 Project was able to effectively implement its second strategy and provide peer educational services to African American students at VCU. The fifth evaluation question assessed student's responses to the Viewpoint: The Black Perspective events. These events took the form of edutainment, being framed as talk shows hosted by VCU students. Event evaluations forms were provided to audience members who were encouraged to fill them out and return the forms to evaluation staff after the event had concluded. Reaction to the first three events: 1) *Sex, Drugs, You and Your Boo*, 2) *Sweet Temptations*, and 3) *Evening at the Improv* are discussed.

During the development of the first three events, the project staff utilized a variety of methods for reaching the student population. The first event, *Sex, Drugs, You and Your Boo*, consisted of a panel discussion and a question and answer period. While these were effective methods for presenting HIV information, the students' comments on the evaluation forms requested more opportunities to participate. As such, the project worked to integrate this need into the next event, *Sweet Temptations*. The panel discussion was removed and replaced with a HIV knowledge game. The audience was provided clickers to answer HIV questions and compete for prizes. A particularly well received aspect of the first event was a skit in which students acted out a commercial promoting HIV awareness. Due to the positive response, the third event, *Evening at the Improv*, expanded on this idea. Students were given the opportunity to form groups and develop their own skits. This was one of the highest attended events and the first to be developed with the help of student organizations. Subsequent events followed this framework and the results indicate the project was able to develop a viable format consisting of student cohosts, questions and answer activities, and games or skits.

The sixth question assessed whether the project's HIV testing events reached their target population. The process evaluation indicated the project successfully reached its target population, as African Americans made up the majority of students who received a free HIV test. . From 2011 to 2015, 981 students were tested for HIV. . The percentage of African American students at each testing event ranged from 42% to 69%. African Americans made up 55% of all students tested. These findings indicate that the project was able to implement its third strategy of providing free HIV testing services to students on campus.

Summary of the Outcome Evaluation

The seventh evaluation question assessed whether the Raise 5 Project maintained adequate retention rates for participants in the evidence based interventions. The overall retention rate for participants was 87%. SISTA had a retention rate of 94% (n = 126), while Nia's was 84% (n=71). Safe in the City had a retention rate of 80% (n = 83). Safe in the City's lower retention rate may be due to the fact it was a single session intervention. Safe in the City may not provide enough time for participants to bond with each other and their facilitators. This lack of connection may have contributed to the lower retention rates. Another point to consider is that Safe in the City cohorts were less racially and ethnically homogenous. Every Nia participant was African American, while only four SISTA participants were not African American. However, fourteen Safe in the City participants were not African American. Out of twelve Safe in the City cohorts, only five were exclusively African American. The racially diverse environment of Safe in the City may have contributed to participants not connecting as much as they did to SISTA or Nia. Also, Safe in the City was not always facilitated by an African American. In addition, Safe in the City was devoid of gender or ethnic themes as it was not specifically designed for African Americans.

There was also difference in the retention rates of SISTA and Nia. SISTA only lost about 6% of participants at follow-up, while Nia lost about 16% of its participants. A potential explanation is SISTA's participants were more committed to the intervention. This may be due to the core element of increasing self-worth by promoting gender and ethnic pride. This focus on gender and ethnicity is not found in Nia and may have contributed to men having less interest in continuing the program. Despite these differences, follow-up retention was generally strong across all three groups.

The eighth evaluation question assessed whether participants across all evidence based interventions demonstrated reduced HIV and substance abuse risk. Because Safe in the City participants only completed data collection at two time points, their outcomes could not be assessed in a mixed ANOVA with SISTA and Nia participants. As a result, one set of analyses was conducted for SISTA and Nia, another set was conducted for Safe in the City. Among SISTA and Nia participants, there were a number of positive outcomes. Participants demonstrated a statistically significant reduction in negative condom attitudes from pre-test to post-test. However, this reduction in condom attitudes was not maintained at follow-up.

SISTA and Nia participants had several other positive outcomes which were maintained at three month follow-up including increased condom negotiation, condom efficacy, and HIV knowledge. In addition, there were significant decreases in negative HIV testing attitudes and HIV conspiracy beliefs. There was also a statistically significant increase in the percentage of students tested from post-test to follow-up.

In contrast, the results also suggest that Safe in the City was far less effective in producing positive outcomes. There was only one significant positive outcome, with participants demonstrating a significant reduction in their number of sexual partners. However, Safe in the City participants also reported more negative condom attitudes from post-test to follow-up. The lack of differences in drug outcomes can be explained by the fact that Safe in the City did not discuss drug use. It should be noted that due to the limitations of the design, pre-test data for Safe in the City were not collected. As such, the impact of the intervention could not be fully assessed.

The results demonstrated a higher degree of effectiveness for SISTA than Safe in the City. At post-test and follow-up, women in SISTA had significantly greater scores for several outcomes

including condom negotiation, condom efficacy, HIV testing attitudes, and HIV knowledge.

Also, women in Safe in the City had significantly higher HIV conspiracy beliefs than women in SISTA at post-test and follow-up.

There were no significant differences between SISTA and Safe in the City on 30 day alcohol use, days drunk over the last 30 days, and 30 day marijuana use at post-test. However, at follow-up, women in Safe in the City had significantly greater 30 day alcohol use, and they also had gotten drunk at a significantly higher rate than women in SISTA.

SISTA was able to achieve several of its intended outcomes. There are several potential reasons why SISTA was more effective than Safe in the City. First, SISTA consisted of skill-building activities (i.e., role playing and practicing correct condom use using penis models). Also, SISTA lasted five weeks, giving participants more time to learn new HIV or safer sex information and incorporate it into their lifestyles. Furthermore, SISTA's multi-session format allowed for the establishment of greater rapport and peer support, which can contribute to the promotion of positive health behaviors and the reduction of risky behaviors (Belgrave et al., 2010).

A key weakness of single session interventions is that they offer limited opportunities for participants to bond with each other and establish networks of social support. An exception is an intervention called *Healthy Love*, which consists of pre-determined social networks of women (Diallo, Moore, Ngalame, White, Herbst, & Painter, 2010). Having pre-established social networks may be important to consider when delivering single-session interventions.

Participants may be more receptive to safer sex messages if they are delivered in the context of peers with whom they have built a relationship with and with whom they have rapport. This is something which can develop naturally over the course of a five week intervention. It is much

more difficult to create in a single session. This may be a key reason for SISTA's greater effectiveness.

Additionally, SISTA may have been more effective because it was specifically developed for African American women. Cultural relevance and ethnically homogeneous intervention groups may increase an intervention's effectiveness as culture influences the way people process messages about gender, sexuality, health, and illness (Vinh-Thomas, Bunch, & Card, 2003). SISTA's gender and cultural relevance may have made the HIV and safer sex information more relevant to participants than Safe in the City. Research suggests that the single-session interventions that demonstrate the most positive risk-reduction outcomes are those designed exclusively for African Americans (Eaton et al., 2012). As such, Safe in the City may not be an effective intervention among African American women. African American women in college likely have their own set of unique sexual experiences. As such, women in SISTA were likely to have relevant discussions that could not occur in Safe in the City, in which African American women were in the presence of men and women from other racial or ethnic groups. For example, a study by Ferguson, Quinn, Eng, and Sandelowski (2006) found that African American women in college noted that few African American men were available to be sexual partners. The women in this study suggested this led to a pattern of "man-sharing," as African American men could have multiple sexual partners. In addition, women suggested that these men felt they could determine if condom use would occur. It is not likely this type of conversation could occur in Safe in the City. African American women may not feel comfortable enough to have these types of conversations with African American men or women from other racial or ethnic groups. Discussing these types of experiences with other women may have been more beneficial than watching the Safe in the City video. In summary, the results

indicated SISTA was significantly more effective than Safe in the City. These findings support earlier work indicating SISTA was effective in increasing positive outcomes such as positive condom attitudes and condom negotiation (Belgrave et al., 2008; Belgrave et al., 2010; DiClemente & Wingood, 1995; Wingood & DiClemente, 2006).

The tenth evaluation question assessed if men in Nia had reduced HIV and substance abuse risk compared to than those in Safe in the City. The findings suggest that Nia was not as effective as SISTA. At post-test, men in Nia had only had significantly higher scores for two outcomes: HIV knowledge and condom efficacy. These significant findings can be explained by the fact Nia specifically targeted HIV knowledge and condom efficacy. For example, Nia participants viewed several videos and engaged in activities designed to increase their HIV knowledge. They also practiced correct condom use with penis models. However, at follow-up, the HIV knowledge and condom efficacy scores among Nia participants decreased. Unexpectedly, men in Safe in the City had significantly more positive condom attitudes than men in Nia at post-test and follow-up.

There are a number of potential explanations for this result. First, it should be noted that the Safe in the City video is specifically focused on demonstrating the need for condoms and promoting their use. The video consists of three vignettes demonstrating real world scenarios in which condom use is necessary. In between each vignette, a brief clip provides information on how to use condoms properly. As such, it is possible that Safe in the City was simply more effective at promoting positive condom attitudes.

Another potential reason why Nia participants reported negative condom attitudes may be because Nia groups consisted of African American men, whereas Safe in the City groups consisted of men and women from different racial or ethnic backgrounds. Research suggests that

some African American men regard negative condom attitudes and a lack of condom use as an important sign of masculinity (Pleck, Sonenstein, & Ku, 1993). It is possible that some Nia participants felt pressured to fit in with the other African American men, leading them to express negative condom attitudes.

It is also possible that African American males did not perceive themselves as at risk for HIV. As such, they did not feel the information provided was relevant for them. It is also possible that multi-session interventions are not the best method of providing prevention services to African American men. Because men are less relational, they may not connect to group discussions in the same way as African American women. These findings suggest that multi-session interventions may not carry the same benefits for African American men as they do for African American women.

The eleventh evaluation question assessed if Enhanced SISTA participants had reduced HIV and substance use risk compared to women in Standard SISTA. The findings indicated that the Raise 5 Project's adapted Enhanced SISTA was no more effective than the standard intervention. At post-test and follow-up, there were no significant differences on sexual risk outcomes, attitudes, or knowledge.

However, there was one significant difference in a drug outcome. Unexpectedly, women in Enhanced SISTA had significantly greater 30 day alcohol use than those in Standard SISTA at post-test and follow-up. There were no significant differences in the number of days participants got drunk or 30 day marijuana use. This suggests that Enhanced SISTA had the opposite effect of what was intended, making participants more comfortable engaging in alcohol use. As such, project staff will likely need to re-evaluate Enhanced SISTA in order to prevent similar effects from occurring in future projects.

The twelfth evaluation question assessed whether African American college students demonstrated reduced HIV and substance use due to the peer education events and the social marketing campaign. In order to answer this question, responses to the National College Health Assessment were analyzed. A variety of sexual risk and drug use items were compared across the years 2010 and 2014. Analyses indicated that there were no significant differences in sexual risk and drug use between 2010 and 2014. This suggests that the second and fourth strategies of the Raise 5 Project (peer education events and the social marketing campaign) had a limited impact on the African American students attending VCU. It should also be noted that the social marketing campaign was the least extensive aspect of the project. Social marketing was not implemented consistently and only one Stall Seat Journal publication featured the Raise 5 Project. This issue of the Stall Seat Journal was published in Fall 2011. In addition, it is possible that many of the students who completed the NCHA were not exposed to the Raise 5 Project.

Implications

There are a number of implications derived from this evaluation. The findings suggest that the Raise 5 Project was able to effectively implement three of its strategies: 1) evidence based interventions, 2) peer education and awareness events, and 3) free HIV testing and counseling. The first project delivered three evidence based interventions: SISTA, Nia, and Safe in the City. SISTA was significantly more effective than Nia and Safe in the City, providing evidence of the continued use of evidence based interventions among African American women. Although multi-session interventions are more time intensive and cost more money than single-session interventions, it may be worth the cost to continue investing in them if they are more effective. For future projects, it may be better to utilize strategies that reduce

the expenses of multi-session interventions than using single session interventions. For instance, technology and social media could be used to implement interventions, volunteers could be trained as facilitators, and non-monetary incentives could be given to participants.

The results of the outcome evaluation indicated that Nia had limited effectiveness. These findings contradict past studies which showed that Nia participants were more likely to use condoms after participating in the intervention (Kalichman et al., 1999). More research is needed to assess if Nia is effective among African American college students. If not, adaptations to this intervention may be needed. These interventions for African American men may follow the format and theme of SISTA and seek to increase gender and ethnic pride. However, it is possible that multi-session group interventions may not be the best method for providing HIV prevention services to African American males.

The findings also demonstrated that Safe in the City had limited effectiveness. While multi-session interventions may be more effective it is likely that single session interventions will continue to be used due to their feasibility. As such, it is important for single session interventions to integrate as many elements of multi-session interventions as possible. For instance, effective single-session interventions should provide opportunities for hands on skills training and find ways to engender rapport between participants.

The process evaluation indicated that the second and third strategies (e.g., peer education events and free HIV testing services) were effectively implemented among the college population. Over 600 students attended the project's edutainment events. The process evaluation findings indicate that the Raise 5 Project's use of edutainment was effective in reaching the African American students at VCU. Students gave positive reviews to these events and requested more opportunities to participate in them. As such, later events included activities

(i.e., skits, games, etc.) designed to provide students with more opportunities to participate in the edutainment events. The results indicate that students gained valuable new information about HIV and substance abuse. It is likely the strong response is tied to the entertaining manner in which the information was presented.

The findings of the process evaluation also suggest that the Raise 5 Project was able to increase access to HIV testing and close to 1,000 students were tested for HIV from 2011 to 2015. A key aspect of this effort was advertising and offering the tests in visible and accessible areas such as the Student Commons. Many students may not know where to seek out services on a large college campus. An additional benefit was that the project likely increased student's knowledge of the sexual health services available to them on campus, in case they were needed in the future. The implementation of the Raise 5 Project's strategies can serve as a potential guide for researchers seeking to deliver prevention services to college students, a population that has been largely ignored (Lewis et al., 2009).

The results of the outcome evaluation indicate that the project's fourth strategy (social marketing campaign) had a limited impact on African American students attending VCU. A potential explanation is that many African American students were simply not exposed to the Raise 5 Project despite all of the project's strategies: evidence based interventions, having multiple peer education and testing events each year, and having a social media presence on Facebook and Twitter. In addition, African American college students may have held low perceptions of their HIV risk, believing they are invulnerable to HIV (Demmer & Caroleo, 2001). As such, some students may have been exposed to the Raise 5 Project, but not benefit from it. As such, future prevention programs should try to assess more effective ways of reaching the target population. While the Raise 5 was successful in working with several

student organizations, it took time to build these relationships. Thus, future programs could aim to develop relationship with the target population before implementing their prevention projects.

Limitations

While this evaluation provides an in depth assessment of the Raise 5 Project, there were some limitations that must be considered. One limitation was in the evaluation of the evidence based interventions, which utilized a quasi-experimental design. As such, participants were not randomly assigned to intervention type. It is possible that the individuals who chose to participate in the multi-session interventions were more motivated to gain HIV knowledge and reduce risk. A further limitation was that pre-test data from Safe in the City participants was not collected due to design considerations (i.e., the funder did not require pre-test data on participants in single session interventions) and an evaluation of between groups differences of sexual risk at pre-test could not be examined. However, analyses of demographic variables between the two groups showed no differences.

While the findings suggested that SISTA was more effective than Safe in the City, other factors may have accounted for differences in sexual risk. Although both were evidence based, SISTA was specifically developed for African American women and Safe in the City was developed for ethnically and racially diverse patients in STI clinics. As such, comparing SISTA to a single-session intervention developed specifically for African Americans (e.g., *Healthy Love*) may have yielded different results.

Another limitation was that different facilitators were used for the interventions. All SISTA and Nia facilitators were African American, while Safe in the City facilitators could be of a different racial or ethnic background (e.g. Asian American). Previous research suggests that

racial-matching of facilitators and participants can improve intervention outcomes, especially among African Americans (Yancey, Ortega, & Kumanyika, 2006).

There were also limitations in the evaluation of the social marketing campaign. An important factor in the success of a campaign includes the audience's level of exposure, which may influence behavior change (Tellis, 2004; Hornik et al., 2007). While the staff at the Wellness Resource Center was able to include items assessing exposure to the Stall Seat Journal, none assessed exposure to the Raise 5 Project. Another important limitation was the fact that the evaluation only assessed behavior change. As such, it was unable to detect potential changes in knowledge or attitudes. The project was limited in its ability to assess changes in attitudes, knowledge, and behavior. It should also be noted that it is possible that the social marketing campaign served as a source of contamination for participants in the evidence based interventions, being responsible for potential additive effects.

There was also another potential limitation for the evaluation, which was the fact that I was a staff member of Raise 5 and therefore an internal evaluator. Since external evaluators are not a part of the programs they are evaluating, they may have a more objective perspective (Worthen, Sanders, & Fitzpatrick, 1997). As such, external evaluators may be considered more credible to outside audiences. However, I believe the benefits of using an internal evaluator outweigh this limitation. As the internal evaluator, I possessed knowledge of Raise 5's history. Also, I was familiar with the project's target population and could conduct the evaluation using a culturally competent perspective that may not have been provided with an external evaluator. Gall, Gall, and Borg (2003) suggest that most evaluations can be performed by an internal evaluator, especially when the evaluation findings are used to guide program management and

decision making. Thus, the fact that the Raise 5 Project utilized an internal evaluator was not a major limitation.

Dissemination of Information

An important consideration of an evaluation is how the results will be shared with the funder and with project staff. The dissemination of the evaluation will take the form of a final report to be submitted to the funder, CSAP. As the Raise 5 Project was funded by a demonstration grant, the effectiveness of the project may influence the implementation of similar projects in the future. CSAP will determine if and how the evaluation results will be shared. Project staff will work closely with the funder to determine appropriate evaluation audiences and potential strategies for dissemination of the information.

Data collected for this evaluation will be shared with additional project staff to develop future scientific publications or technical reports. Preliminary project findings have already been presented at conferences including the American Public Health Association's Annual Meeting and Exposition in October 2014 and the VCU Poster Symposium for Undergraduate Research and Creativity in May 2014. In addition, articles have been published (or are in press). The Raise 5 Project will continue to disseminate information through presentations at local conferences and by publishing in various journals.

Sustainability

As funding for the Raise 5 Project has entered its fifth and final year, sustainability becomes the project's primary focus. Sustainability efforts have included the establishment of a Raise 5 student organization to ensure that partners are able to continue delivering HIV and substance use prevention services on campus. Staff have identified and trained students to have the necessary HIV knowledge and skills to deliver the HIV and substance abuse prevention

services. Because many of the partnering organizations (i.e., The Wellness Resource Center, Fan Free Clinic) already provide services to the target population, they have staff and organizational resources to continue providing HIV and substance prevention services after the end of the Raise 5 Project.

Recommendations

This section identifies the suggested next steps in the implementation of HIV and substance abuse prevention programs among college students. The first set of recommendations is related to the project's first strategy of utilizing evidence based interventions. The findings suggest the continued use of multi-session interventions such as SISTA among African American women. The findings also indicated that an adapted version of Safe in the City was not effective. As such, future programs should utilize a more traditional intervention (e.g., skill based) rather than Safe in the City, which lacks a curriculum and is essentially a video designed to be shown in STI clinics.

Another recommendation for future work is to assess if single-session interventions designed for African American women are as effective as multi-session interventions designed for this group. Some single session interventions developed for African Americans include *Healthy Love* or *VOICES* (Diallo et al., 2010; O'Donnell, O'Donnell, San Doval, Duran, & Labes, 1998). Future studies could assess the differences between SISTA and these types of interventions. The evaluation also suggests that multi-session interventions were no more effective than single session interventions among African American men. As such, future research should assess if multi-session interventions hold the same effectiveness for African American men as for African American women. If not, more effective methods for reaching African American men should be developed.

There are also recommendations based on the peer education and awareness events, the project's second strategy. The Raise 5 Project developed a series of peer educational programs which were very well received by African American students. Respondents reported gaining new knowledge and planning to incorporate it into their lifestyle. As such, these findings support past research which suggests that peers are an effective method for providing health education messages (Mahat et al., 2008; Solomon & Flynn, 2005; Stephenson et al., 2004). Students greatly enjoyed the edutainment format, which may be a key reason for the positive response. As such, it is recommended that future peer education prevention programs use games, skits, and various opportunities for student participation.

The evaluation of the project's third strategy demonstrated the effectiveness of providing free HIV testing and counseling. Therefore, it is recommended that future projects utilize similar methods, such as providing services in conveniently located and highly accessible areas, and not requiring an appointment. The findings of the outcome evaluation suggest that there is room for improvement in regard to the social marketing campaign. It is recommended that before a project begins that staff determine if adequate resources are available so that it can be implemented consistently. In addition, outcome measures should be consistently utilized for the duration of the project and there should be measures to adequately assess the respondent's level of exposure to the project.

Conclusions

This evaluation report indicates that Raise 5 Project was a well-received HIV and substance prevention program for African American students at VCU. Across the peer education events and evidence based interventions, participants were very positive about the project, staff, and the project incentives. Over 600 students attended the project's peer

education events and close to 1,000 students received a free HIV test. In both cases, the majority of students identified as African American. With regard to the evidence based interventions, SISTA was very effective and the women consistently reported increased HIV knowledge, condom negotiation skills, and condom use efficacy. Qualitative evidence suggests that SISTA helped participants increase their assertiveness and feel empowered about other areas of their lives. The same level of effectiveness was not found for Nia or Safe in the City. In conclusion, the Raise 5 Project provided effective HIV prevention services to African American college students. It is hoped by the project staff and the evaluator that this evaluation will be utilized by future projects to identify the best steps when implementing HIV and substance abuse prevention programs.

List of References

List of References

- Adefuye, A.S., Abiona, T.C., Balogun, J.A., & Lukobo-Durrell, M. (2009). HIV sexual risk behaviors and perception of risk among college students: Implications for planning interventions. *BMC Public Health*, 9, 281.
- Aggleton, P., & Campbell, C. (2000). Working with young people—Towards an agenda for sexual health. *Sexual and Relationship Therapy*, 15, 283–296.
- American College Health Association. (2011). Undergraduate group data reference report. Retrieved from http://www.acha-ncha.org/pubs_rpts.html
- American College Health Association. (2006). American College Health Association National College Health Assessment (ACHA-NCHA) Spring 2005 reference group data report (Abridged). *Journal of American College Health*, 55, 5-16.
- Aragon, R., Kates, J., & Greene, L. (2001). *African Americans' views of the HIV/AIDS epidemic at 20 Years*. Menlo Park, CA: Kaiser Family Foundation.
- Arnett, J.J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, 55, 469–480.
- Barth, K.R., Cook, R.L., Downs, J.S., Switzer, G.E., & Fischhoff, B. (2002). Social stigma and negative consequences: Factors that influence college students' decisions to seek testing for sexually transmitted infections. *Journal of American College Health*, 50(4), 153–159.
- Bazargan, M., Kelly, E.M., Stein, J.A., Husaini, B.A., & Bazargan, S.H. (2000). Correlates of HIV risk-taking behaviors among African-American college students: The effect of HIV knowledge, motivation, and behavioral skills. *Journal of the National Medical Association*, 92, 391-404.
- Belgrave, F.Z., Corneille, M.A., Hood, K.B., Foster-Woodson, J., & Fitzgerald, A. (2010). The impact of perceived group support on the effectiveness of an HIV prevention program for African American women. *Journal of Black Psychology*, 36(2), 127-143.
- Belgrave, F.Z., Corneille, M.A., Nasim, A., Fitzgerald, A., & Lucas, V. (2008). An evaluation of an Enhanced Sisters Informing Sisters about Topics on AIDS (SISTA) HIV Prevention Curriculum: The role of drug education. *Journal of HIV/AIDS & Social Services*, 7(4), 313-327.

- Belgrave, F.Z., Reed, M.C., Plybon, L.E., & Corneille, M.A. (2004). The impact of a culturally enhanced drug prevention program on drug and alcohol refusal efficacy among urban African American girls. *Journal of Drug Education*, 34, 267-279.
- Berkowitz, A.D. (2005). An overview of the social norms approach. In L.C. Lederman, L.P. Stewart, F. Goodhart, & L. Laitman (Eds.), *Changing the culture of college drinking* (pp. 143–214). Cresskill, NJ: Hampton Press.
- Bersamin, M.M., Paschall, M.J., Saltz, R.F., & Zamboanga, B.L. (2012). Young adults and casual sex: The relevance of college drinking settings. *Journal of Sex Research*, 49(2-3), 274–281.
- Bogart, L.M. & Thorburn, S. (2005). Are HIV/AIDS conspiracy beliefs a barrier to HIV prevention among African Americans? *Journal of Acquired Immune Deficiency Syndrome*, 38(2), 213-218.
- Borsari, B.B., & Carey, K.B. (2003). Descriptive and injunctive norms in college drinking: a meta-analytic integration. *Journal of Studies on Alcohol and Drugs*, 64, 331–341.
- Boshamer, C.B., & Bruce, K.E. (1999). A scale to measure attitudes about HIV-antibody testing: development and psychometric validation. *AIDS Education and Prevention*, 11(5), 400-413.
- Brack, A.B., Millard, M., & Shah, K. (2008). Are peer educators really peers? *Journal of American College Health*, 56, 566-568.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, Massachusetts: Harvard University Press.
- Buhi, E.R., Marhefka, S.L., & Hoban, M.T. (2010). The state of the union: Sexual health disparities in a national sample of US college students. *Journal of American College Health*, 58, 337–346.
- Campbell, C. (2004). Creating environments that support peer education: Experiences from HIV/AIDS-prevention in South Africa. *Health Education*, 104(4), 197-200.
- Centers for Disease Control and Prevention. (2014a). HIV/AIDS among African Americans. Retrieved from <http://www.cdc.gov/hiv/risk/raciaethnic/aa/facts/index.html>
- Centers for Disease Control and Prevention. (2014b). Sexually Transmitted Disease Surveillance 2012. Retrieved from <http://www.cdc.gov/hiv/risk/raciaethnic/aa/facts/index.html><http://www.cdc.gov/std/stats12/surv2012.pdf>

- Centers for Disease Control and Prevention. (2014c). HIV among youth. Retrieved from http://www.cdc.gov/hiv/pdf/risk_youth_fact_sheet_final.pdf
- Centers for Disease Control and Prevention. (2013a). HIV surveillance report, Vol. 23. Retrieved from http://www.cdc.gov/hiv/pdf/statistics_2011_HIV_Surveillance_Report_vol_23.pdf
- Centers for Disease Control and Prevention. (2013b). Fact sheet: HIV in the United States. Retrieved from http://www.cdc.gov/hiv/pdf/statistics_basics_factsheet.pdf
- Centers for Disease Control and Prevention. (2013c). HIV surveillance supplemental report, Vol. 18, No. 5. Retrieved from http://www.cdc.gov/hiv/pdf/2011_Monitoring_HIV_Indicators_HSSR_FINAL.pdf
- Centers for Disease Control and Prevention. (2013d). HIV and substance use in the United States. Retrieved from http://www.cdc.gov/hiv/pdf/risk_hiv_substance.pdf
- Centers for Disease Control and Prevention. (2012a). HIV surveillance supplemental report, Vol. 17, No. 4. Retrieved from http://www.cdc.gov/hiv/pdf/statistics_hssr_vol_17_no_4.pdf
- Centers for Disease Control and Prevention. (2012b). Trends in HIV-related risk behaviors among high school students—United States, 1991-2011. *Morbidity and Mortality Weekly Report*, 61, 556-560.
- Centers for Disease Control and Prevention. (2011). HIV among youth. Retrieved from <http://www.cdc.gov/hiv/youth/pdf/youth.pdf>
- Centers for Disease Control and Prevention. (2010). Sexually transmitted disease surveillance 2009. Retrieved from <http://www.cdc.gov/std/stats09/surv2009-Complete.pdf>
- Centers for Disease Control and Prevention. (2008). Estimates of the new HIV infections in the United States. Retrieved from <http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/incidence.htm>
- Centers for Disease Control and Prevention. (2008). Sisters informing sisters about topics on AIDS (SISTA) Implementation Manual. Retrieved from https://effectiveinterventions.cdc.gov/docs/default-source/sista-implementation-materials/SISTA_IM_Black_and_White_-_sept_08_for_website-without_covers.pdf?sfvrsn=0
- Centers for Disease Control and Prevention. (2006). Epidemiology of HIV/AIDS- United States, 1981- 2005. *Morbidity and Mortality Weekly Report* 55, 589- 592.
- Centers for Disease Control and Prevention. (2001). Revised guidelines for HIV counseling, testing, and referral. *Morbidity and Mortality Weekly Report*, 50, 1–58.

- Chapman, S., Stoker, L., Ward, M., Porritt, D., & Fahey, P. (1990). Discriminant attitudes and beliefs about condoms in young, multipartner heterosexuals. *International Journal of STD and AIDS*, 1, 422 - 428.
- Chen, C., Dufour, M., & Yi, H. (2004). Alcohol consumption among young adults ages 18–24 in the United States: Results from the 2001– 2002 NESARC survey. *Alcohol Research & Health*, 28, 269–280.
- Chng, C., Carlon, A., & Toynes, B. (2006). HIV on historically Black colleges and universities (HBCU): A study of five campuses in Texas, Oklahoma, Louisiana. *College Student Journal*, 40(1), 25-34.
- Coffman, J. (1999). *Learning from logic models: An example of a family/school partnership program*. Harvard Family Research Project, Cambridge, MA.
- Cohn, L.D., Macfarlane, S., Yanez, C., & Imai, W.K. (1995). Risk perception: Differences between adolescents and adults. *Health Psychology*, 14, 217–222.
- Cook, R. L., & Clark, D.B. (2005). Is there an association between alcohol consumption and sexually transmitted diseases? A systematic review. *Sexually Transmitted Diseases*, 32(3), 156-164.
- Cooper, M.L. (2002). Alcohol use and risky sexual behavior among college students and youth: Evaluating the evidence. *Journal of Studies on Alcohol*, (Supplement 14), 101 – 117.
- Crosnoe, R., & McNeely, C. (2008). Peer relations, adolescent behavior, and public health research and practice. *Family & Community Health*, 31(S1), S71–S80.
- Darbes, L., Crepaz, N., Lyles, C., Kennedy, G., & Rutherford, G. (2008). The efficacy of behavioral interventions in reducing HIV risk behaviors and incident sexually transmitted diseases in heterosexual African Americans. *AIDS*, 22, 1177-1194.
- DeJong, W., Schneider, S., Towvim, L., Murphy, M.J., Doerr, E.E., Simonsen, N.R., & Scribner, R.A. (2006). A multisite randomized trial of social norms marketing campaigns to reduce college student drinking. *Journal of Studies on Alcohol*, 67(6), 868–879.
- DeJong, W., Towvim, L. G., & Schneider, S. K. (2008). Support for alcohol control policies and enforcement strategies among U.S. college students at 4-year institutions. *Journal of American College Health*, 56, 231–236.
- Demmer, C., & Caroleo, O. (2001). College students' perceptions of advances in HIV treatment and the need for safer sex practices. *Psychological Reports*, 88, 431–442.

- Diallo, D. D., Moore, T. W., Ngalame, P. M., White, L. D., Herbst, J. H., & Painter, T. M. (2010). Efficacy of a single-session HIV prevention intervention for black women: A group randomized controlled trial. *AIDS and Behavior*, 14, 518-529.
- DiClemente, R.J., & Wingood, G.M. (1995). A randomized controlled trial of an HIV sexual risk reduction intervention for young African-American women. *Journal of the American Medical Association*, 274 (16), 1271-1276.
- DiClemente, R., Wingood, G., Harrington, K., Lang, D., Davies, S., Hook, E., & Robillard, A., (2004). Efficacy of an HIV prevention intervention for African American adolescent girls. *Journal of the American Medical Association*, 292(2), 171–179.
- Dilorio, C., Dudley, W., & Soet, J. (1998). Predictors of HIV risk among college students: A CHAID analysis. *Journal of Applied Biobehavioral Research*, 3(2), 119–134.
- Duncan, C., Miller, D.M., Borskey, E.J., Fomby, B., Dawson, P., & Davis, L. (2002). Barriers to safe sex practices among African American college students. *Journal of the National Medical Association*, 94, 944-951.
- Ebrahim, S.H., Anderson, J.E., Weidle, P., & Purcell, D.W. (2004). Race/ethnic disparities in HIV testing and knowledge about treatment for HIV/AIDS: United States, 2001. *AIDS Patient Care and STDs*, 18(1), 27-33.
- Eisen, M., Pallitto, C., Bradner, C., & Bolshun, N. (2000). Teen risk-taking: Promising prevention programs and approaches. Retrieved from http://www.urban.org/Uploadedpdf/TeenRiskTaking_2.pdf
- El Bcheraoui, C., Sutton, M.Y., Hardnett, F.P., & Jones, S.B. (2013). Patterns of condom use among students at historically black colleges and universities: Implications for HIV prevention efforts among college-age young adults. *AIDS Care*, 25, 186-193.
- Espinosa-Hernandez, G., & Lefkowitz, E. (2009). Sexual behaviors and attitudes and ethnic identity during college. *Journal of Sex Research*, 46(5), 471–482.
- Fang, X., Stanton, B., Li, X., Feigelman, S., & Baldwin, R. (1998). Similarities in sexual activity and condom use among friends within groups before and after a risk-reduction intervention. *Youth and Society*, 29, 430-451.
- Fielder, R.L., & Carey, M.P. (2010a). Predictors and consequences of sexual “hookups” among college students: A short-term prospective study. *Archives of Sexual Behavior*, 39(5), 1105–1119.
- Fielder, R.L., & Carey, M.P. (2010b). Prevalence and characteristics of sexual hookups among first-semester female college students. *Journal of Sex & Marital Therapy*, 36(4), 346–359.

- Fielder, R.L., Carey, K.B., & Carey, M.P. (2013). Are hookups replacing romantic relationships? A longitudinal study of first-year female college students. *Journal of Adolescent Health, 52*(5), 657-659.
- Fischer, E. H., Dornelas, E. A., & Goethe, J. W. (2001). Characteristics of people lost to attrition in psychiatric follow-up studies. *Journal of Nervous and Mental Disease, 189*, 49–55.
- Fisher, J.C., Cook, P.A., Sam, N.E., & Kapiga, S.H. (2008). Patterns of alcohol use, problem drinking, and HIV infection among high-risk African women. *Sexually Transmitted Diseases, 35*(6), 537–544.
- Fisher, J.D., & Fisher, W.A. (1992). Changing AIDS-risk behavior. *Psychological Bulletin, 111*, 455-474.
- Fletcher, P.C., Schneider, M.A., Dawson, K.A., & Vandermeer, A. (2007). Health issues and service utilization of university students: Experiences, practices & perceptions of students, staff and faculty. *College Student Journal, 41*, 482–493.
- Frieden, T.R., Das-Douglas, M., Kellerman, S.E., & Henning, K.J. (2005). Applying public health principles to the HIV epidemic. *New England Journal of Medicine, 353* (Supplement 1), 2397–2402.
- Ford, C.L., Daniel, M., Earp, J.L., Kaufman, J.S., Golin, C.E., & Millner, W.C. (2009). Perceived everyday racism, residential segregation, and HIV testing among patients at a sexually transmitted disease clinic. *American Journal of Public Health, 99* (Supplement 1), 137–143.
- Fullilove, R.E. (2006). African Americans, health disparities, and HIV/AIDS: Recommendations for confronting the epidemic in African American America. Washington, DC: National Minority AIDS Council. Retrieved from www.nmac.org/index/cmsfilesystemaction?file=grpp/african%20americans,%20health%20disparities%20and%20hiv/aids.pdf
- Fromme, K., D'Amico, E., & Katz, E. (1999). Intoxicated sexual risk taking: An expectancy or cognitive impairment explanation. *Journal of Studies on Alcohol, 60*, 54–63.
- Gall, M. D., Gall, J. P., & Borg, W. R. (2003). Educational research: An introduction (7th ed.). Boston, MA: A & B Publications
- Galvin, D. (2005) Measuring results from outreach and education programs: Can we see improvements downstream? Manuscript from 4th National Conference on Nonpoint Source and Stormwater Pollution Education Programs, October 2005, Chicago, Illinois.
- Garneau, C., Olmstead, S.B., Pasley, K., & Fincham, F.D. (2013). The role of family structure and attachment in college student hookups. *Archives of Sexual Behavior, 42*(8), 1473-1486.

- Gillen, M.M., Lefkowitz, E.S., & Shearer, C.L. (2006). Does body image play a role in risky sexual behavior and attitudes? *Journal of Youth and Adolescence*, 35, 243-255.
- Graves, K.L., & Leigh, B. (1995). The relationship of substance abuse to sexual activity among young adults in the United States. *Family Planning Perspectives*, 27, 18–22.
- Gould, J.M., & Lomax, A.R. (1993). The evolution of peer education: Where do we go from here? *Journal of American College Health*, 45, 235-240.
- Harshbarger, C.L., O'Donnell L.N., Warner L., Margolis A.D., Richardson D.B., Novey, S.R., et al. (2012). Safe in the city: effective prevention interventions for human immunodeficiency virus and sexually transmitted infections. *American Journal of Preventive Medicine*, 42(5), 468-72.
- Haines, M.P., & Spear, S. F. (1996). Changing the perception of the norm: a strategy to decrease binge drinking among college students. *Journal of American College Health*, 45, 134–140.
- Herbst, J.H., Kay, L.S., Passin, W.F., Lyles, C.M., Crepaz, N., & Marin, B.V. (2007). A systematic review and meta-analysis of behavioral interventions to reduce HIV risk behaviors of Hispanics in the United States and Puerto Rico, *AIDS and Behavior* 11(1), 25–47.
- Hightow, L.B., Leone, P.A., MacDonald, P.D.M., McCoy, S.I., Sampson, L.A., & Kaplan, A.H. (2006). Men who have sex with men and women: A unique risk group for HIV transmission on North Carolina college campuses. *Sexually Transmitted Diseases*, 33(10), 585-593.
- Holmes, K.K., Levine, R., & Weaver, M. (2004). Effectiveness of condoms in preventing sexually transmitted infections. *Bulletin of the World Health Organization*, 82, 454–461.
- Hornik, R., Jacobs, L. & Coffman, J. (2007) Evaluating communication campaigns: A report of the 2007 Research and Evaluation Conference. Robert Wood Johnson Foundation, reported by Lori DeMillo. Available online at:
<http://www.rwjf.org/files/research/evaluatingcommcampaings2008.pdf>
- Hou, S.-I. (2009). HIV-related behaviors among black students attending Historically Black Colleges and Universities (HBCUs) versus white students attending a traditionally white institution (TWI). *AIDS Care*, 21(8), 1050-1057.
- Hou, S.-I., & Wisenbaker, J. (2005). Using a web-based survey to assess correlates of intention towards HIV testing among never-been-tested but sexually experienced college students. *AIDS Care*, 17(3), 329 – 334.

- Hutton, H., McCaul, M., Santora, P., & Erbeling, E. (2008). The relationship between recent alcohol use and sexual behaviors: Gender differences among sexually transmitted disease clinic patients. *Alcoholism: Clinical and Experimental Research*, 32, 1–8.
- Irwin, K. L., Valdiserri, R.O., & Holmbert, S.D. (1996). The acceptability of voluntary HIV antibody testing in the United States: A decade of lessons learned. *AIDS*, 10, 1707-1717.
- Kaiser Family Foundation (2014). HIV testing in the United States. Retrieved from <http://kaiserfamilyfoundation.files.wordpress.com/2014/05/6094-14-hiv-testing-in-the-united-states1.pdf>
- James-Traore, T., Magnani, R., Murray, N., Senderowitz, J., Speizer, I., & Stewart, L. (2002). Intervention strategies that work for youth: Summary of the FOCUS on young adults end of program report (Youth Issues Paper No. 1). Arlington, VA: Family Health International, YouthNet Program.
- Janz, N.K., Champion, V., & Strecher, V.J. (2002). The health belief model. In K. Glanz, B. K. Rimer, & F. M. Lewis (Eds.), *Health behavior and health education: Theory, research, and practice* (pp. 45–66). San Francisco: Jossey-Bass.
- Jemmott III, J.B., Jemmott, L.S., Braverman, P.K., & Fong, G.T. (2005). HIV/STD risk reduction interventions for African American and Latino adolescent girls at an adolescent medicine clinic: a randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine*, 159(5), 440–449.
- Jemmott, L.S., Jemmott III, J.B., & O’Leary, A. (2007). Effects on sexual risk behavior and STD rate of brief HIV/STD prevention interventions for African American women in primary care settings. *American Journal of Public Health*, 97(6), 1034–1040.
- Johnson, R.L., Roter, D.L., Powe, N.R., & Cooper, L.A. (2004). Patient race/ethnicity and quality of patient-physician communication during medical visits. *American Journal of Public Health*, 94, 2084-2090.
- Justus, A.N., Finn, P.R., & Steinmetz, J.E. (2000). The influence of traits of disinhibition on the association between alcohol use and risky sexual behavior. *Alcoholism: Clinical and Experimental Research*, 24(7), 1028–1035.
- Kahler, C.W., Read, J.P., Wood, M.D., & Palfai, T.P. (2003). Social environmental selection as a mediator of gender, ethnic, and personality effects on college student drinking. *Psychology of Addictive Behaviors*, 17, 226–234.
- Kaiser Family Foundation (2014). HIV testing in the United States. Retrieved from <http://kaiserfamilyfoundation.files.wordpress.com/2014/05/6094-14-hiv-testing-in-the-united-states1.pdf>

- Kaiser Family Foundation. (November, 2012). National survey of teens and young adults on HIV/AIDS. Menlo Park, CA: Kaiser Family Foundation.
- Kaiser Family Foundation (2002). Substance use and risky sexual behavior: Attitudes and practices among adolescents and young adults. Retrieved from <http://www.hawaii.edu/hivandaids/Substance%20Use%20and%20Risky%20Sexual%20Behavior%20Survey%20Snapshot.pdf>
- Kalichman, S.C., Carey, M.P., & Johnson, B.T. (1996). Prevention of sexually transmitted HIV infection: Meta-analytic review and critique of the theory-based intervention outcome literature. *Annals of Behavioral Medicine*, 18, 6-15.
- Kalichman, S., Cherry, C., Browne-Sperling, F. (1999). Effectiveness of a video-based motivational skills-building risk-reduction intervention for inner-city African American men. *Journal of Consulting and Clinical Psychology*, 67(6), 959-966.
- Kanekar, A., & Sharma, M. (2010). Determinants of safer sex behaviors among college students. *ACTA DIDACTICA NAPOCENSIA*, 3, 27–38.
- Kapner, D. A. (2008) Alcohol and other drug use at Historically Black Colleges and Universities. Retrieved from <http://files.eric.ed.gov/fulltext/ED537617.pdf>
- Lambert, T., Kahn, A., & Apple, K. (2003). Pluralistic ignorance and hooking up. *Journal of Sex Research*, 40(2), 129–133.
- Lance, L. (2001). HIV/AIDS perceptions and knowledge: Heterosexual college students within the context of sexual activity: Suggestions for the future. *Student College Journal*, 35, 401–410.
- Leigh, B.C., & Aramburu, B. (1996). The role of alcohol and gender in choices and judgments about hypothetical sexual encounters. *Journal of Applied Social Psychology*, 26, 20–30.
- Lewis, M.A., Granato, H., Blayney, J.A., Lostutter, T.W., & Kilmer, J.R. (2012). Predictors of hooking up sexual behaviors and emotional reactions among U.S. College students. *Archives of Sexual Behavior*, 41(5), 1219–1229.
- Lewis, J.E., Miguez-Burbano, M.J., & Malow, R.M. (2009). HIV risk behavior among college students in the United States. *College Student Journal*, 43, 475-491.
- Lyles, C.M., Kay, L.S., Crepaz, N., Herbst, J.H., Passin, W.F., Kim, A.S., Rama, S.M., Thadiparthi, S., DeLuca, J.B., Mullins, M.M., HIV/AIDS Prevention Research Synthesis Team. (2007). Best-evidence interventions: findings from a systematic review of HIV behavioral interventions for US populations at high risk, 2000–2004. *American Journal of Public Health*, 97(1), 133–143.

- Maguen, S., Armistead, L.P., & Kalichman, S. (2000). Predictors of HIV antibody testing among Gay, Lesbian, and bisexual youth. *Journal of Adolescent Health, 26*(4), 252–257.
- Mahat, G., Scoloveno, M.A., De Leon, T., & Frenkel, J. (2008). Preliminary evidence of an adolescent HIV/AIDS peer education program. *Journal of Pediatric Nursing, 23*, 358-363.
- Mancoske, R., Rountree, M., Donovan, M., & Neighbors, I. (2006). HIV/AIDS knowledge and perceptions among African American male and female college students at a historically black university. *Journal of HIV/AIDS & Social Services, 5*, 221–231.
- Maticka-Tyndale, E., & Barnett, J.P. (2010). Peer-led interventions to reduce HIV risk of youth: A review. *Evaluation and Program Planning, 33*, 98-1120.
- Mehrotra, P., Noar, S.M., Zimmerman, R.S., & Palmgreen, P. (2009). Demographic and personality factors as predictors of HIV/STD partner-specific risk perceptions: Implications for interventions. *AIDS Education and Prevention, 21*(1), 39-54.
- Milligan, C., Cuneo, C.N., Rutstein, S.E., & Hicks, C. (2014). “Know your status”: Results from a novel, student-run HIV testing initiative on college campuses. *AIDS Education and Prevention, 26*(4), 317-327.
- Montano, D. E., & Kasprzyk, D. (2002). The theory of reasoned action and the theory of planned behavior. In K. Glanz, B. K. Rimer, & F. M. Lewis (Eds.), *Health behavior and health education: Theory, research, and practice* (pp. 67–98). San Francisco: Jossey-Bass.
- Morris, M., Handcock, M.S., Miller, W.C., Ford, C.A., Schmitz, J.L., Hobbs, M.M. et al. (2006). Prevalence of HIV infection among young adults in the United States: Results from the Add Health Study. *American Journal of Public Health, 96*(6), 1091–1097.
- Morrison, T.C., DiClemente, R.J., Wingood, G.M., & Collins, C. (1998). Frequency of alcohol use and its association with STD/HIV-related risk practices, attitudes and knowledge among an African-American community-recruited sample. *International Journal of STD & AIDS, 9*, 608–612.
- Moseley, K.L., Freed, G.L., Bullard, C.M., & Goold, S.D. (2007). Measuring African-American parents' cultural mistrust while in a healthcare setting: a pilot study. *Journal of the National Medical Association, 99*(1), 15-21.
- Neighbors, C., Lee, C.M., Lewis, M.A., Fossos, N., & Larimer, M.E. (2007). Are social norms the best predictor of outcomes among heavy-drinking college students? *Journal of Studies on Alcohol and Drugs, 68*, 556–565.
- Ness, R.B., Randall, H., Richter, H.E., et al. (2004). Condom use and the risk of recurrent pelvic inflammatory disease, chronic pelvic pain, or infertility following an episode of pelvic inflammatory disease. *American Journal of Public Health, 94*, 1327–1329.

- Nigg C.R., Allegrante J.P., & Ory, M. (2002). Theory-comparison and multiple-behavior research: Common themes advancing health behavior research. *Health Education & Research*, 17, 670–679.
- NIH Panel. (1997). National Institutes of Health consensus development statement on interventions to prevent HIV risk behaviors. Bethesda, MD: NIH Office of Medical Applications Research.
- Norris, A., & Ford, K. (1998). Moderating influences of peer norms on gender differences in condom use. *Applied Developmental Science*, 2, 174-181.
- Norris, J., Masters, N.T., & Zawacki, T. (2004). Cognitive mediation of women’s sexual decision-making: The influence of alcohol, contextual factors, and background variables. *Annual Review of Sex Research*, 15, 258–296.
- Nguyen, A., Clark, T. T., Hood, K. B., Corneille, M., & Belgrave, F. Z. (2010). Looking beyond traditional gender roles and identity: Do reconceptualizations affect condom-related outcomes? *Culture, Health and Sexuality*, 24, 603-617.
- O'Donnell, C.R., O'Donnell, L., San Doval, A., Duran, R., & Labes, K. (1998). Reductions in STD Infections Subsequent to an STD Clinic Visit: Using Video-based Patient Education to Supplement Provider Interactions. *Sexually Transmitted Diseases*, 25(3), 161 – 168.
- Opt, S., & Loffredo, D. (2004). College students and HIV/AIDS: More insights on knowledge, testing, and sexual practices. *The Journal of Psychology*, 138, 389–403.
- Owen, J., Fincham, F.D., & Moore, J. (2011). Short-term prospective study of hooking up among college students. *Archives of Sexual Behavior*, 40(2), 331–341.
- Owen, J., Rhoades, G., Stanley, S., & Fincham, F. (2010). “Hooking up” among college students: Demographic and psychosocial correlates. *Archives of Sexual Behavior*, 39(3), 653–663.
- Parkin, S., & McKeganey, N. (2000). The rise and rise of peer education approaches. *Drugs: Education, Prevention, and Policy*, 7, 293-310.
- Paul, E.L., & Hayes, K.A. (2002). The casualties of ‘casual’ sex: A qualitative exploration of the phenomenology of college students’ hookups. *Journal of Social and Personal Relationships*, 19, 639–661.
- Paul, E.L., McManus, B., & Hayes, K.A. (2000). ‘Hookups’: Characteristics and correlates of college students’ spontaneous and anonymous sexual experiences. *Journal of Sex Research*, 37(1), 76–88.

- Payne, N., Beckwith, C., Davis, M., Flanigan, T., Simmons, E., Crockett, K... Sly, K. (2006). Acceptance of HIV testing among African American college students at a historically black university in the south. *Journal of the National Medical Association*, 98, 1912–1916.
- Perkins, H.W. (2003). The emergence and evolution of the social norms approach to substance abuse. In H. W. Perkins (ed.), *The social norms approach to preventing school and college age substance abuse: A handbook for educators, counselors, and clinicians* (pp. 3-17). San Francisco: Jossey-Bass.
- Perkins, H.W. (1997). College student misperceptions of alcohol and other drug norms among peers: Exploring causes, consequences, and implication for prevention programs. In *Designing alcohol and other drug prevention programs in higher education* (pp. 177–206). Newton, MA: Higher Education Center for Alcohol and Other Drug Prevention, Department of Education.
- Perkins, H.W. & Berkowitz, A.D. (1986). Perceiving the community norms of alcohol use among students: Some research implications for campus alcohol education programming. *International Journal of the Addictions*, 21, 961-976.
- Perkins, H.W., Meilman, P., Leichliter, J.S., Cashin, J.R., & Presley, C. (1999). Misperceptions of the norms for the frequency of alcohol and other drug use on college campuses. *Journal of American College Health*. 47, 253–258.
- Phinney, J. (1992). The multigroup ethnic identity measure: A new scale for use with adolescents and young adults from diverse groups. *Journal of Adolescent Research*, 7, 156-176.
- Polich, J.M., Armor, D.J., & Braiker, H.B. (1980). *The course of alcoholism: Four years after treatment*. Santa Monica, CA: The Rand Corporation.
- Porter, M. (2013, February 26). The stall seat journal: 10 years of ‘aha and ha-ha’ health news. VCU News. Retrieved from [http://www.news.vcu.edu/article/The Stall Seat Journal 10 Years of Aha and HaHa Health News](http://www.news.vcu.edu/article/The_Stall_Seat_Journal_10_Years_of_Aha_and_HaHa_Health_News)
- Poulson, R.L., Bradshaw, S.D., Huff, J.M., Peebles, L.L., & Hilton, D. (2008). Risky sex behaviors among African American college students: The influence of alcohol, marijuana, and religiosity. *North American Journal of Psychology*, 10, 529-542.
- Prather, C., Fuller, T.R., King, W., Brown, M., Moering, M., Little, S., & Phillips, K. (2006). Diffusing an HIV prevention intervention for African American women: integrating Afrocentric components into the SISTA diffusion strategy. *AIDS Education and Prevention* 18, 149–160.

- Raj, A., Reed, D., Santana, M.C., Walley, A.Y., Welles, S.L., Horsburgh, C.R., et al. (2009). The associations of binge alcohol use with HIV/STI risk and diagnosis among heterosexual African American men. *Drug and Alcohol Dependence*, 101, 101-106.
- Marks, G., Crepaz, N., & Janssen, R.S. (2006). Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. *AIDS*, 20(10), 1447-50.
- Rose, M. (2008). African American college freshman students' knowledge, attitudes, beliefs, and behaviors related to HIV: A preliminary investigation. *The Internet Journal of Allied Health Sciences and Practice*, 6, 1-7.
- Ross, L.L., & Bowen, A.M. (2010). Sexual decision making for the "better than average" college student. *Journal of American College Health*, 59, 211-216.
- Rossi, P., Lipsey, M.W., & Freeman, H.E. (2004). *Evaluation: a systematic approach* (7th ed.). Thousand Oaks: Sage.
- Royce, C., Perlmuter Silverman, P., & Krauss, B. (2007). A brief, low-cost, theory-based intervention to promote dual method use by Black and Latina female adolescents: a randomized clinical trial. *Health Education & Behavior*, 34(4), 608-621.
- Rutstein, S., Mugavero, M., Sullivan, C., Bickers-Bock, L., & Hicks, C. B. (2006, August). Enhancing voluntary HIV testing among university students—The Know Your Status (KYS) program. Paper presented at AIDS 2006—XVI International AIDS Conference, Toronto.
- Satterwhite, C.L., Torrone, E., Meites, E., et al. (2013). Sexually transmitted infections among U.S. women and men: prevalence and incidence estimates, 2008. *Sexually Transmitted Diseases*, 40(3), 187-93.
- Scholly, K., Katz, A.R., Gascoigne, J., & Holck, P.S. (2005). Using social norms theory to explain perceptions and sexual health behaviors of undergraduate college students: An exploratory study. *Journal of American College Health*, 53(4), 159 – 166.
- Scott-Sheldon, L., Carey, M., Vanable, P., Seen, T., Coury-Doniger, P., & Urban, M. (2009). Alcohol consumption, drug use, and condom use among STD clinic patients. *Journal of Studies on Alcohol and Drugs*, 70, 762-770.
- Seth, P., Sales, J.M., DiClemente, R.J., Wingood, G.M., Rose, E., & Patel, S.N. (2011). Longitudinal examination of alcohol use: A predictor of risky sexual behavior and *Trichomonas vaginalis* among African American female adolescents. *Sexually Transmitted Diseases*, 38, 96-101.
- Shiner, M. (1999). Defining peer education. *Journal of Adolescence*, 22, 555-566.

- Siebert, D.C., Wilke, D., Delva, J., Smith, M., & Howell, R. (2003). Differences in African American and White college students' drinking behaviors: Consequences, harm reduction strategies, and health information sources. *Journal of American College Health*, 52, 123–129.
- Simon, J.L. & Arndt, J. (1980) The shape of the advertising return function. *Journal of Advertising Research*, Vol. 20, No. 4, August 1980, 11-28.
- Solomon, L.J., & Flynn, B.S. (2005). Telephone support for pregnant smokers who want to stop smoking. *Health Promotion Practice*, 6, 105-108.
- Spence, J.T., Helmreich, R., & Stapp, J. (1974). The personal attributes questionnaire: A measure of sex-role stereotypes and masculinity-femininity. *Journal Supplement Abstract Service: Catalog of Selected Documents in Psychology*, 4, 127.
- Steinberg, L. (2008). A social neuroscience perspective on adolescent risk-taking. *Developmental Review*, 28, 78-106.
- Stephenson, J.M., Strange, V., Forrest, S., Oakely, A., Copas, A., Allesen, E., et al., (2004). Pupil-led sex education in England (RIPPLE study): Cluster-randomized intervention trial. *The Lancet*, 364, 338-346.
- Stinson, R.D. (2010). Hooking up in young adulthood: A review of factors influencing the sexual behavior of college students. *Journal of College Student Psychotherapy*, 24(2), 98–115. Substance Abuse and Mental Health Services Administration (2013). Results from the 2012 national survey on drug use and health: Summary on national findings. Retrieved from <http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.pdf>
- Sutton, M., Hardnett, F., Wright, P., Wahi, S., Pathak, S., Warren-Jeanpiere, L., & Jones, S. (2011). HIV/AIDS knowledge scores and perceptions of risk among African American students attending historically black colleges and universities. *Public Health Reports*, 126, 653–663.
- Tellis, G.J. (2004) *Effective advertising: Understanding when, how and why advertising works*. Sage Publications, University of South Carolina.
- Thomas, P., Voetsch, A., Song, B., Galloway, D., Goode, C., Munday, L., . . . Heffelfinger, J. (2008). HIV risk behaviors and testing history in historically black college and university settings. *Public Health Reports*, 123, 115–125.
- Thompson-Robinson, M.V., Richter, M.L., Shegog, M., Weaver, L.T., Sellars, D.B., & Brown, V.L. (2005). Perception of partner risk and influences on sexual decision-making for HIV

- prevention among students at Historically Black Colleges & Universities. *Journal of African American Studies*, 9(2), 16-28.
- Turner, B.J., Cunningham, W.E., Duan, N., et al. (2000). Delayed medical care after diagnosis in a US national probability sample of persons infected with human immunodeficiency virus. *Archives of Internal Medicine*, 160(17), 2614–2622.
- Turner, G., & Shepherd, J. (1999). A method in search of a theory: Peer education and health promotion. *Health Education Research*, 14(2), 235–247.
- University of Texas Southwestern Medical Center. (2008). Nia Facilitator's Guide. Retrieved from https://effectiveinterventions.cdc.gov/docs/default-source/nia-implementation-materials/Nia_FacilitatorsGuide-Nov2010.pdf?sfvrsn=0
- Vaillant, G.E. (1975). Evaluation of treatment through the long-term follow-up. In H. Bostrum, T. Larsson, & N. Ljungstedt (Eds.), *Drug dependence: Treatment and treatment evaluation* (pp. 262- 269). Stockholm: Almqvist and Wiksell
- Vander Ven, T., & Beck, J. (2009). Getting drunk and hooking up: An exploratory study of the relationship between alcohol intoxication and casual coupling in a university sample. *Sociological Spectrum*, 29, 626–648.
- Vladyslava, Z. (2014). Modern research concept of edutainment. Retrieved from <http://euroasia-science.ru/files/arhiv/07.2014/p11.pdf#page=123>
- Wallace, J.M., & Muroff, J.R. (2002). Preventing substance abuse among African American children and youth: Race differences in risk factor exposure and vulnerability. *The Journal of Primary Prevention*, 22(3), 235-261.
- Warner, L., Klausner, J.D., Rietmeijer, C.A., Malotte, C.K., O'Donnell, L., Margolis, A.D., Greenwood, G.L., Richardson, D., Vrungos, S., O'Donnell, C.R., and Borkowf, C.B., for the Safe in the City Study Group (2008). Effect of a brief video intervention on incident infection among patients attending sexually transmitted disease clinics. *PLoS Medicine* 5(6), e135.
- Washington Post/Kaiser Family Foundation. (2012). 2012 survey of Americans on HIV/AIDS. Retrieved from <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8334-f.pdf>
- Wechsler, H., Lee, J., Kuo, M., Seibring, M., Nelson, T., & Lee, H. (2002). Trends in college binge drinking during a period of increased prevention efforts. *Journal of American College Health*, 50(5), 203–217.
- Wechsler, H., Lee, J.E., Nelson, T.F., & Kuo, M. (2002). Underage college students' drinking behavior, access to alcohol, and the influence of deterrence policies. *Journal of American College Health*, 50(5), 223–236.

- Weller, S., & Davis, K. (2002). Condom effectiveness in reducing heterosexual HIV transmission. *Cochrane Database of Systematic Reviews*, 1, CD003255.
- Williams, J.K., Wyatt, G.E., & Wingood, G. (2010). The four Cs of HIV prevention with African Americans: Crisis, condoms, culture, and community. *Current HIV/AIDS Reports*, 7(4), 185-193.
- Winfield, E., & Whaley, A. (2002). A comprehensive test of the health belief model in the prediction of condom use among African American college students. *Journal of Black Psychology*, 28, 330–345.
- Wingood, G. M., & DiClemente, R. J. (2006). Enhancing adoption of evidence-based HIV interventions: promotion of a suite of HIV prevention interventions for African American women. *AIDS Education and Prevention*, 18(4 Suppl A), 161-170.
- Wingood, G. M., & DiClemente, R. J. (1998). The influence of psychosocial factors, alcohol, drug use on African-American women's high-risk sexual behavior. *American Journal of Preventive Medicine*, 15, 54–59.
- Worthen, B.R., Sanders, J.R., & Fitzpatrick, J.L. (1997). *Program evaluation: Alternative approaches and practical guidelines*, 2nd Edition. White Plains, NY: Longman Publishers.

Appendix A

Peer Education Event Flyers



point: The Black Perspective presents...

SEX DRUGS YOU and your BOO

February 1st

7:00 PM

Student Commons
Theater

FREE

REFRESHMENTS

FREEBIES FOR EVERYONE

A Talk Show Live
And In Living Color To
Answer All Your Questions
About Sex And Drugs

Featuring Special Guest Hosts,
Experts and Students.
Calling all greek and non-greek
organizations.

REPRESENT!

Sponsored by the VCU Center for Cultural Experiences in Prevention
in partnership with the Office of Multicultural Affairs, the
Community Health Education Program (SOE), the Department of African
American Studies, The Wellness Center and Fan Free Clinic
Info Contact: 828-6261 Dsbutler@vcu.edu

RAISE 5 PROJECT PRESENTS:



SWEET TEMPTATIONS

VIEWPOINT: THE BLACK PERSPECTIVE

SEPTEMBER 7, 2011 AT 7:00PM

COMMONS THEATER

Sweet Treats, Tips, & Giveaways

RAISE5PROJECT@GMAIL.COM
(804) 828- 6261

LIKE US



FOLLOW US



A romantic couple, a woman with curly hair and a man, are shown in profile, about to kiss. The background is a soft-focus indoor setting with a window. Overlaid on the image is text for a community event.

Healthy Hookup

Thursday September 8th
8pm-9pm
Community Room

Free Condoms & Brownies!
PRESENTED BY THE RAISE 5 PROJECT

**RAISE 5 PROJECT
AND THE LADIES OF
THE ETA TAU CHAPTER
OF DELTA SIGMA
THETA SORORITY, INC.
PRESENT**

*Refreshments
Prizes for Winners*

Viewpoint: The Black Perspective

EVENING AT THE IMPROV

VCU COMMONS THEATRE @ 7:00 PM

Wednesday October 26, 2011



**DON'T BURN
YOUR FRIENDS!**



804-828-6261

RAISE5PROJECT@GMAIL.COM

LIKE US 

FOLLOW US 

THE RAISE 5 PROJECT
 Omega Psi Phi Fraternity Inc.
 N.A.A.C.P. and Black Caucus
 PRESENTS
BATTLE
 OF THE
SEXES
Game Show
February 7, 2012
 VCU Commons Theater
 7:30 PM
 Free Mocktails, Prizes, & More
 Raise 5
 To participate students can pre-register with a team or sign up at the event on a first come first serve basis. For more info contact Joeline at Abramsj@vcu.edu




the5project@gmail.com

Viewpoint: The Black Perspective *Photography by Studioarielle.com*

2.18.2013 @ 7:30PM

COMMONS THEATER

She said she
only been with
4 or 5 dudes, do
I really have to
multiply by 3?

He said he loves
me, should I
give it up?

The Raise 5 Project & The Def Poets Society Present

WHY YOU ASKIN' ALL THEM QUESTIONS

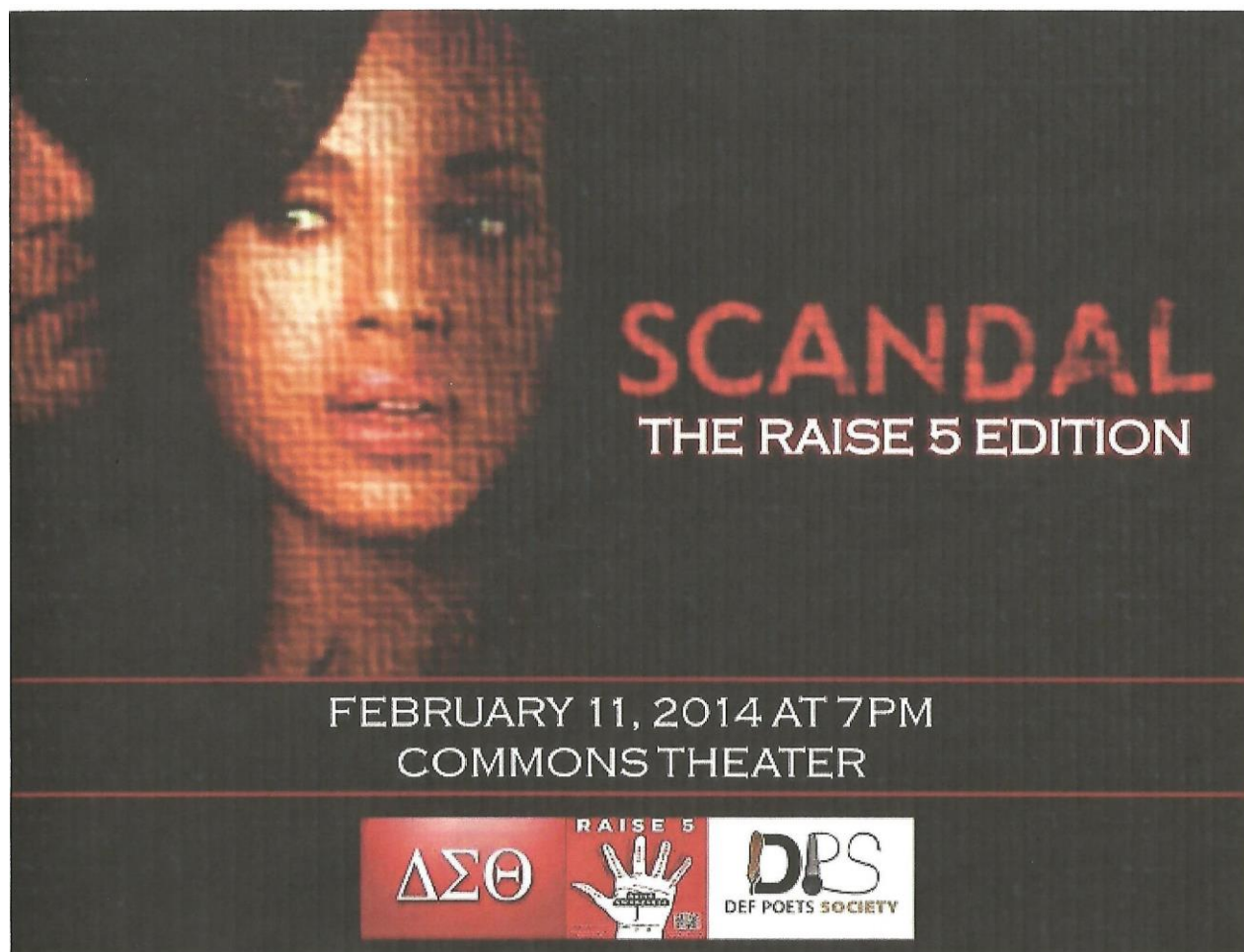
Panel on Relationships & SEX, Refreshments, Prizes
Featuring Representatives from:

ΔΦΩ

ΔΣΘ

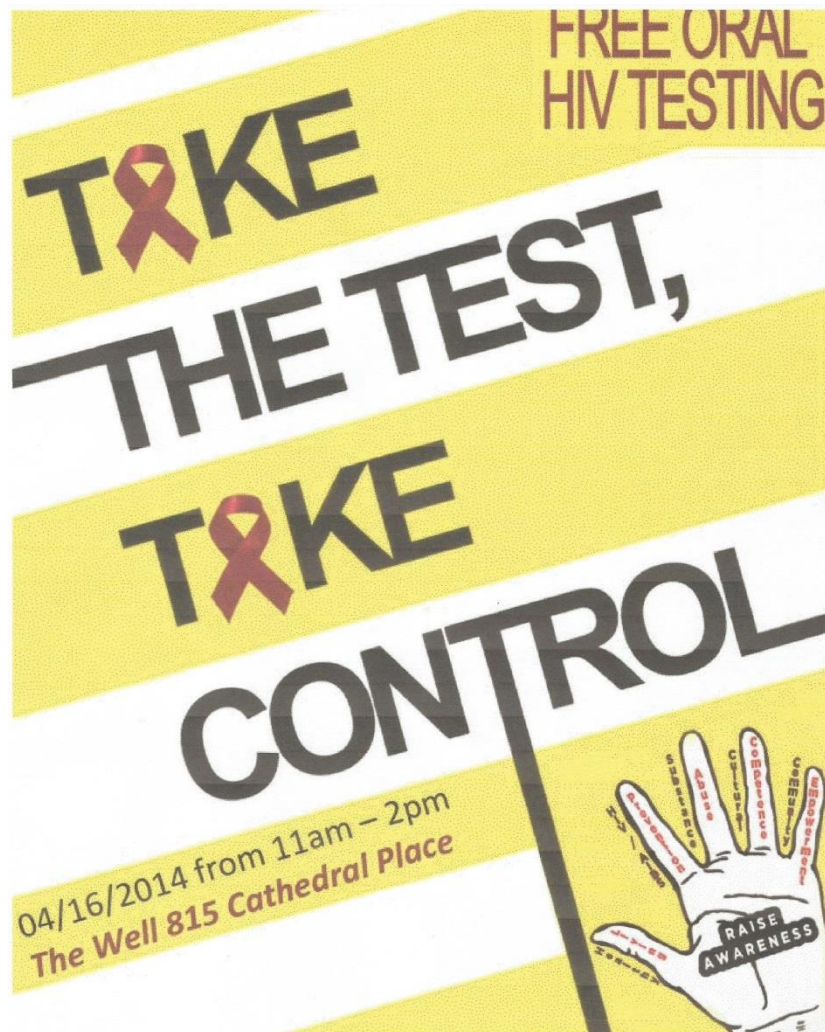
1906
ΑΦΑ

P



Appendix B

HIV Testing Event Flyer



Appendix C

Stall Seat Journal

THE STALL SEAT JOURNAL

Vol. MMXI No. 12 © 2011 Wellness Resource Center, Virginia Commonwealth University Fall 2011

African-American students focus of HIV education project

The Raise 5 Project is a group of VCU students, faculty and staff working together to reduce rates of HIV and substance abuse especially among VCU's African-American students. The Center for Cultural Experiences, directed by Faye Belgrave PhD, obtained a federal grant to fund and lead the project efforts.

African Americans are affected disproportionately. Nationally, African Americans ages 20-24 make up only 16% of the population but constitute 61% of the HIV/AIDS diagnoses (CDC, 2009). We can correct this disturbing statistic if we all know and

- act on the Raise 5 principles:
1. Know your status: Get tested annually for HIV.
 2. Party Smart: Buzzed not bombed!
 3. Use condoms 100%.
 4. Know your resources — testing options, condom sources, education.
 5. Create a campus community of "change-makers" — join Raise 5!

Join us in making a difference:

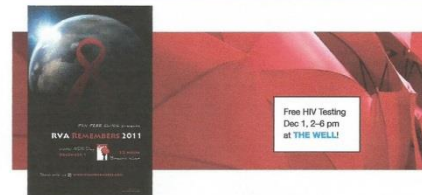
Get tested! The Fan Free Clinic holds monthly free oral HIV testing at **THE WELL** for all VCU students, faculty and staff.

Attend events sponsored by **Viewpoint: The Black Perspective**. These entertaining

and educational programs in the Commons Theater are open to all. Invite everyone to be a "change-maker" by "raising" the Raise 5 Project Facebook page and following us on Twitter to stay up on events and testing dates. (We follow back!)

Encourage African-American students to participate in Raise 5 peer education and empowerment groups. Imagine meeting up with a group of your peers — soon-to-be friends — once a week for several weeks for sessions that are interactive, fun and stimulating.

Both SISTA (five-session program for the ladies) and NIA (four sessions for the gentlemen) allow participants to build a comfortable environment for discussing relationships, dating and sex and learning to embrace and be proud of African-American culture. Those who complete SISTA or NIA are eligible to receive up to \$50. The Raise 5 single-session co-ed program, "Safe in the City," is designed to increase awareness. Incentives also are offered to participants in this program.



RVA Remembers — World AIDS Day 2011

Want to be part of a most memorable, poignant and graphic event? During RVA Remembers at noon on Dec. 1, 400 participants will create an enormous AIDS memorial ribbon when each person, standing in an assigned space, opens a red umbrella. The event on Brown's Island marks the 30th year since the

first AIDS diagnosis. Participants will stand in ribbon formation for precisely 3.3 minutes, the time it takes for yet one more American to become newly infected with HIV, the precursor to AIDS. Fan Free Clinic, Virginia's first free medical clinic, is leading this effort to draw attention to the AIDS epidemic that continues in Richmond and Virginia.

Groups as well as individuals can sponsor an umbrella with a duration of approximately \$100. Supporters also may attend and observe the ceremony. Later in the afternoon, Fan Free Clinic will provide free HIV testing at **THE WELL** (2-6 pm). For details about participation: WWW.RVAREMEMBERS.COM.

Stressbusting during Finals Week

Understanding stress crushes. Short breaks revive. A laugh, a breath, power nap, a 30-minute work out, an hour yoga class — small acts that refresh and refocus. Here's another. Join the Ram ExScream at the Compass Dec 8 at 9 pm or Dec 11 at 6 pm. Free goody bags with VCU ID while supplies last.

Here's a little inspiration to cheer you on toward self-care during this stressful month:

"Take care of your body. It's the only place you have to live." — Jim Rohn
 "Tension is who you think you should be. Relaxation is who you are." — Chinese Proverb
 "Sometimes the most important thing in a whole day is the rest we take between two deep breaths." — Etty Hillesum



The Stall Seat Journal is published by The Well

804-920-3353 • www.thewell.vcu.edu • 615 S. Cathedral Place
 Strategic history research: www.YouState.org
 Division of Student Affairs and Enrollment Services
 University Student Health Services • www.students.vcu.edu/health



Appendix D

Raise 5 Event Evaluation Survey

EVALUATION

Viewpoint: The Black Perspective

We would appreciate your assistance in evaluating this educational forum so that we can improve future events.

Please circle your response to the following items:

5= Strongly Agree

4=Agree

3=Neither Agree/Disagree

2=Disagree

1=Strongly Disagree

The Raise 5 Project

I learned new information about The Raise 5 Project

5 4 3 2 1

I intend to share information with my friends about The Raise 5 Project

5 4 3 2 1

My friends would be interested in learning more about The Raise 5 Project

5 4 3 2 1

My friends would interested in attending Viewpoint: The Black Perspective events

5 4 3 2 1

I am interested in finding out more information about The Raise 5 Project

5 4 3 2 1

I would like to participate in future Raise 5 Project events and programs

5 4 3 2 1

I would be interested in participating in a multi-cultural collaboration with The Raise 5 Project

5 4 3 2 1

What did you think about our program?

The information was very valuable

5 4 3 2 1

I gained new knowledge about HIV/AIDS

5 4 3 2 1

I gained new knowledge about substance abuse

5 4 3 2 1

I intend to incorporate what I learned about HIV/AIDS into my lifestyle

5 4 3 2 1

I intend to incorporate what I learned about substance abuse into my lifestyle

5 4 3 2 1

Please circle your response to the following items:

5= Strongly Agree

4=Agree

3=Neither Agree/Disagree

2=Disagree

1=Strongly Disagree

The event was interactive

5 4 3 2 1

The event was entertaining

5 4 3 2 1

The event was too long

5 4 3 2 1

The event was too short

5 4 3 2 1

The event was appropriate for college students

5 4 3 2 1

The room size was appropriate

5 4 3 2 1

The event was easy to locate

5 4 3 2 1

The event exceeded my expectations

5 4 3 2 1

For the following questions, please indicate the answer that best represents your response. If you prefer more than one answer, use "1" to indicate your first preference, "2" for your second preference, "3" for your third preference, etc.

How did you find out about this event?

___ email ___ word of mouth ___ flyer ___ Facebook ___ twitter ___ classroom announcement ___ other*

*Please specify _____

What would be the best way to inform you or your friends about similar future events?

___ email ___ word of mouth ___ flyer ___ Facebook ___ twitter ___ classroom announcement ___ other*

*Please specify _____

If you were going to personally inform your friends about similar future events, how would you inform them?

___ email ___ word of mouth ___ flyer ___ Facebook ___ twitter ___ classroom announcement ___ other*

*Please specify _____

Would you be interested in participating in similar future events?

___ yes ___ no ___ I don't know

If so, how often would you be interested in attending these events?

___ once a month ___ once a semester ___ twice a semester ___ once a year

What is your racial or ethnic group? _____ What is your major? _____

What is your gender?

___ male ___ female

What is your class standing?

___ freshman ___ sophomore ___ junior

___ senior ___ graduate student

Please share any comments or suggestions on how we could improve future events:

Appendix E

Fan Free Clinic Survey

FFC SURVEY

All survey responses are anonymous. Please answer each question honestly. Thank you for your time!

Race: (check all that apply)

- ☐ American Indian/AK Native ☐ White
- ☐ Black/African American ☐ Asian
- ☐ Native HI/Pac. Islander ☐ Hispanic
- ☐ Don't know

Sex: ☐ Male ☐ Female

☐ TG M2F ☐ TG F2M

HIV Risk factors: Which of the following responses would provide the best explanation as to why you believe you may have been at risk for HIV. Please check all that apply:

- ☐ Multiple sexual partners
- ☐ Sex with someone whose HIV status you did not know or were not sure about
- ☐ Sex with someone you did not know very well
- ☐ Knowing or suspecting that one of your

In the past year, do you feel that the use of drugs or alcohol has caused you to do the following: (check all that apply)

- ☐ Engage in unprotected sex
- ☐ Choose to have sex with an anonymous partner/someone you did not know very well

Appendix F

Outcome Evaluation Measures

RAISE 5 Program Survey

These questions will help us understand how you feel about things like sex, drugs, and alcohol. Your answers will be kept strictly confidential, which means your family, friends, and others in the RAISE 5 project will not know how you answered the questions.

Please do not write your name anywhere on the survey, except on this page. Please tear off this cover page and give it to the data collector. You have been assigned an ID number that will be used during the entire RAISE 5 Program. These numbers help us keep your answers confidential.

This is not a test, so there are no right or wrong answers. If you come to a question that you do not want to answer, you do not have to. If you do not understand a question, please ask the person administering the survey.

We think you will find the questions to be interesting and that you will like answering them.

Thank you for being an important part of the RAISE 5 Program!

The items below ask about what kind of person you think you are. For example, the first question asks you where you fall between the extremes of “not at all aggressive” and “very aggressive.” “A” would indicate “not at all aggressive” while “E” would indicate “very aggressive.”

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. Not at all <u>aggressive</u> | A | B | C | D | E | Very <u>aggressive</u> |
| 2. Not at all <u>independent</u> | A | B | C | D | E | Very <u>independent</u> |
| 3. Not at all <u>emotional</u> | A | B | C | D | E | Very <u>emotional</u> |
| 4. Very <u>submissive</u> | A | B | C | D | E | Very <u>dominant</u> |
| 5. Not at all <u>excitable</u> in a major crisis | A | B | C | D | E | Very <u>excitable in a</u> <u>major crisis</u> |
| 6. Very <u>passive</u> | A | B | C | D | E | Very <u>active</u> |
| 7. Not at all able to <u>devote self</u> <u>completely to others</u> | A | B | C | D | E | Able to <u>devote self</u> <u>completely to others</u> |
| 8. Very <u>rough</u> | A | B | C | D | E | Very <u>gentle</u> |
| 9. Not at all <u>helpful to others</u> | A | B | C | D | E | Very <u>helpful to</u> <u>others</u> |
| 10. Not at all <u>competitive</u> | A | B | C | D | E | Very <u>competitive</u> |
| 11. Very <u>home oriented</u> | A | B | C | D | E | Very <u>worldly</u> |
| 12. Not at all <u>kind</u> | A | B | C | D | E | Very <u>kind</u> |
| 13. <u>Indifferent to others'</u> <u>approval</u> | A | B | C | D | E | <u>Highly needful of</u> <u>others' approval</u> |
| 14. Feelings not <u>easily hurt</u> | A | B | C | D | E | Feelings <u>easily hurt</u> |
| 15. Not at all <u>aware of feelings</u> <u>of others</u> | A | B | C | D | E | Very <u>aware of</u> <u>others feelings</u> |
| 16. Can <u>make decisions easily</u> <u>decisions</u> | A | B | C | D | E | Has <u>difficulty</u> <u>making</u> |
| 17. <u>Gives up</u> very easily | A | B | C | D | E | <u>Never gives up</u> <u>easily</u> |
| 18. Never <u>cries</u> | A | B | C | D | E | <u>Cries</u> very easily |
| 19. Not at all <u>self-confident</u> | A | B | C | D | E | Very <u>self-confident</u> |

| | | | | | | |
|--|---|---|---|---|---|---|
| 20. Feels very <u>inferior</u> | A | B | C | D | E | Feels very <u>superior</u> |
| 21. Not at all <u>understanding of others</u> | A | B | C | D | E | Very <u>understanding of others</u> |
| 22. Very <u>cold in relations with others</u> | A | B | C | D | E | Very <u>warm in relations with others</u> |
| 23. Very little <u>need for security</u> | A | B | C | D | E | Very strong <u>need for security</u> |
| 24. <u>Goes to pieces under under pressure</u> | A | B | C | D | E | <u>Stands up well under pressure</u> |

The following statements are about your attitudes towards using condoms. Please tell how much you agree or disagree with each statement by putting a check mark under your choice.

| | Strongly Disagree | Disagree | Agree | Strongly Agree |
|---|-------------------|----------|-------|----------------|
| 1. My main partner would get mad if I said we had to use a male condom. | _____ | _____ | _____ | _____ |
| 2. Male condoms ruin the mood. | _____ | _____ | _____ | _____ |
| 3. Sex doesn't feel as good when you use a condom. | _____ | _____ | _____ | _____ |
| 4. My main partner would think I was having sex with another person if I said we had to use a condom. | _____ | _____ | _____ | _____ |
| 5. Using male condoms would help build trust between my main partner and me. | _____ | _____ | _____ | _____ |
| 6. Sex with condoms doesn't feel natural. | _____ | _____ | _____ | _____ |
| 7. Using male condoms breaks up the rhythm of sex. | _____ | _____ | _____ | _____ |

The next questions ask about the kinds of situations when it is more difficult for you to use condoms when you have sex with your main partner. Even if the situation has not happened to you, try to imagine how you would handle it if it ever happened. Place a check mark under your choice.

Definitely Probably Probably Definitely

| | No | No | Yes | Yes |
|--|---------------|-------------|--------------|----------------|
| 1. Can you discuss condom use with your main partner? | _____ | _____ | _____ | _____ |
| 2. Can you insist on condom use if your main partner does not want to use one? | _____ | _____ | _____ | _____ |
| 3. Can you stop and look for condoms when you are sexually aroused? | _____ | _____ | _____ | _____ |
| | Definitely No | Probably No | Probably Yes | Definitely Yes |
| 4. Can you insist on condom use every time you have sex even when you are under the influence of drugs? | _____ | _____ | _____ | _____ |
| 5. Can you insist on condom use every time you have sex even when your main partner is under the influence of drugs? | _____ | _____ | _____ | _____ |
| 6. Can you put a condom on your main partner without spoiling the mood? | _____ | _____ | _____ | _____ |
| 7. Can you insist on condom use every time you have sex even if you or your main partner uses another method to prevent pregnancy? | _____ | _____ | _____ | _____ |

The next questions are about your confidence in using condoms with your main partner. Place a check mark under your choice.

Even if you've never used condoms before, how confident or sure are you that you could...

| | Not Confident | Somewhat Confident | Very Confident |
|--|---------------|--------------------|----------------|
| 1. Put a condom on a hard penis. | _____ | _____ | _____ |
| 2. Unroll a condom down correctly on the first try. | _____ | _____ | _____ |
| 3. Start over with a new condom if you placed it on the wrong way. | _____ | _____ | _____ |

- | | | | |
|--|-------|-------|-------|
| 4. Unroll a condom fully to the base of the penis. | _____ | _____ | _____ |
| 5. Squeeze air from the tip of a condom. | _____ | _____ | _____ |
| 6. Take a male condom off without spilling the semen or cum. | _____ | _____ | _____ |
| 7. Take a male condom off before your partner loses their hard on. | _____ | _____ | _____ |
| 8. Dispose of a used condom properly. | _____ | _____ | _____ |
| 9. Use lubricant with a condom. | _____ | _____ | _____ |

The next few questions are about having sex and using condoms.

1. How frequently do you use male condoms?
 - a. Always
 - b. Most of the time
 - c. Some of the time
 - d. Rarely
 - e. Never
 - f. I am not currently sexually active

2. How familiar are you with female condoms?
 - a. Little familiarity- I have never used one
 - b. Some Familiarity – I am familiar with female condoms but have never used one
 - c. Pretty Familiar – I have used occasionally
 - d. Very Familiar – I use regularly

These questions are about your ethnicity and how you feel about or react to it. Please place a check mark on the line that tells us how much you agree or disagree with each statement.

- | | Strongly
Disagree | Disagree | Agree | Strongly
Agree |
|---|----------------------|----------|-------|-------------------|
| 1. I have a clear sense of my ethnic background and what it means for me. | _____ | _____ | _____ | _____ |

- | | | | | |
|--|-------|-------|-------|-------|
| 2. I am happy that I am a member of the group I belong to. | _____ | _____ | _____ | _____ |
| 3. I have a strong sense of belonging to my own ethnic group. | _____ | _____ | _____ | _____ |
| 4. I understand pretty well what my ethnic group membership means to me. | _____ | _____ | _____ | _____ |
| 5. I have a lot of pride in my ethnic group. | _____ | _____ | _____ | _____ |
| 6. I feel a strong attachment towards my own ethnic group. | _____ | _____ | _____ | _____ |
| 7. I feel good about my cultural or ethnic background. | _____ | _____ | _____ | _____ |

| |
|---|
| <p>These questions are about HIV antibody testing and how you feel about it. Please circle the response that indicates how much you agree or disagree with each statement.</p> |
|---|

1. I am afraid that if I were to be tested for HIV, my name would go into public records.

| | | | | | | |
|-------------------|-----------------|-------------------|----------------------------|----------------|--------------|----------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|-------------------|-----------------|-------------------|----------------------------|----------------|--------------|----------------|

2. Anyone who is tested for HIV is disgusting.

| | | | | | | |
|-------------------|-----------------|-------------------|----------------------------|----------------|--------------|----------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|-------------------|-----------------|-------------------|----------------------------|----------------|--------------|----------------|

3. HIV antibody testing is not really confidential.

| | | | | | | |
|-------------------|-----------------|-------------------|----------------------------|----------------|--------------|----------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|-------------------|-----------------|-------------------|----------------------------|----------------|--------------|----------------|

4. I would not consider getting an HIV test because I would be asked about things I have done that could get me into trouble.

| | | | | | | |
|-------------------|-----------------|-------------------|----------------------------|----------------|--------------|----------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|-------------------|-----------------|-------------------|----------------------------|----------------|--------------|----------------|

5. I would be embarrassed if my friends found out I had decided to have an HIV test.

| | | | | | | |
|-------------------|-----------------|-------------------|----------------------------|----------------|--------------|----------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|-------------------|-----------------|-------------------|----------------------------|----------------|--------------|----------------|

6. People would assume I have HIV if I decided to get tested.

| | | | | | | |
|-------------------|-----------------|-------------------|----------------------------|----------------|--------------|----------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|-------------------|-----------------|-------------------|----------------------------|----------------|--------------|----------------|

7. I am afraid someone would find out I was tested for HIV.

| | | | | | | |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|

8. I would not get tested for HIV because I would be asked information that was too personal.

| | | | | | | |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|

9. HIV antibody testing information is kept very confidential by the medical staff who do testing.

| | | | | | | |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|

10. I trust the HIV counselors and nurses to keep my information confidential.

| | | | | | | |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|

Please read the statements below. Circle the statements that will tell us how much you agree or disagree with each statement.

1. The medicines used to treat HIV are saving lives in the black community.

| | | | | | | |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|

2. A lot of information about AIDS is being held back from the public.

| | | | | | | |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|

3. There is a cure for AIDS, but it is being withheld from the poor

| | | | | | | |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|

4. The government is telling the truth about AIDS.

| | | | | | | |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|

5. The medicine used to treat HIV causes people to get AIDS.

| | | | | | | |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|

6. AIDS was created by the government to control the black population.

| | | | | | | |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|

7. People who take the new medicines for HIV are human guinea pigs for the government.

| | | | | | | |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
|----------------------|--------------------|----------------------|-------------------------------|-------------------|-----------------|-------------------|

| | | | | | | |
|-------------------|---|-------------------|----------------------------|----------------|--------------|----------------|
| 8. | Medical and public health institutions are trying to stop the spread of HIV in black communities. | | | | | |
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
| 9. | AIDS was produced in a government laboratory. | | | | | |
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
| 10. | Scientist and doctors can be trusted to tell us the truth about AIDS. | | | | | |
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
| 11. | AIDS was created to kill blacks and poor folks. | | | | | |
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
| 12. | The government has a cure for HIV but will not release it. | | | | | |
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |
| 13. | The drug companies have a vaccine to prevent HIV infection but will not release it. | | | | | |
| Strongly Disagree | Mostly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Mostly Agree | Strongly Agree |

National Minority SA/HIV Prevention Initiative

Cohort 9

Adult Questionnaire

TO BE COMPLETED BY THE LOCAL GRANT SITE DATA COLLECTOR

Last Name _____, First Name _____, M.I. _____

Participant ID #: _____

RESPONDENT OR PARTICIPANT: Before answering any of the questions, please make sure your name is correct. If incorrect, make the change in the box above. Do not write your name on any other page in this questionnaire. Thank you.

National Minority SA/HIV Prevention Initiative

Cohort 9

Adult Questionnaire

Funding for data collection supported by the
Center for Substance Abuse Prevention (CSAP)
Substance Abuse and Mental Health Services Administration (SAMHSA)
U.S. Department of Health and Human Services (HHS)

These questions are part of a data collection effort about how to prevent substance abuse and HIV infection. The questions are being asked of hundreds of other individuals throughout the United States. The data findings will be used to help prevention initiatives learn more about how to keep people from using drugs and getting infected with HIV.

Completing this questionnaire is voluntary. If you do not want to answer any of the questions, you do not have to. However, your answers are very important to us. Please answer the questions honestly—based on what you really do, think, and feel. Your answers will not be told to anyone in your family or community. **Do not write your name anywhere on this questionnaire.**

We would like you to work fairly quickly so that you can finish. Please work quietly by yourself. If you have any questions or don't understand something, let the data collector know.

We think you will find the questionnaire to be interesting and that you will like filling it out. Thank you very much for being an important part of this data collection effort!

Completing this questionnaire will take no more than an average of 50 minutes per person. These questions support performance reporting for the Government Performance Results Act, Performance Assessment Rating Tool, CSAP's National Outcome Measures, and the CSAP Minority AIDS Initiative. Send comments or questions regarding this burden estimate or any other aspect of this collection of information to SAMHSA/CSAP, 1 Choke Cherry Road, Room 5-1115, Rockville, MD 20857.

INSTRUCTIONS

1. Answer each question by marking one of the answer circles. Some questions allow you to mark more than one answer. If you don't find an answer that fits exactly, choose the one that comes closest.
2. Mark your answers carefully so we can tell which answer circle you chose. Do not mark between the circles.
3. It is very important that you answer each question truthfully. Your responses will not be helpful unless you tell the truth.

MARKING YOUR ANSWERS

- Use a No. 2 black lead pencil.
- Do not use an ink or ballpoint pen.
- Make heavy dark marks that fill the circle completely.
- Erase cleanly any answer you wish to change.
- Make no stray marks on this questionnaire.

EXAMPLES

Correct Marks: Incorrect Marks:

☐ ☐ ☐ ☐ ☒ ☒ ☒ ☒

Record Management Section: To be Completed by Designated Staff

Grant ID

| | | | | | | | |
|---|---|--|--|--|--|--|--|
| S | P | | | | | | |
|---|---|--|--|--|--|--|--|

Study Design Group (Select one)

☐ Intervention ☐ Comparison

Participant ID

| | | | | | |
|--|--|--|--|--|--|
| | | | | | |
|--|--|--|--|--|--|

Date of Survey Administration

| | | | | |
|-------|---|-----|---|------|
| | / | | / | |
| Month | | Day | | Year |

Interview Type (Select one)

☐ Baseline ☐ Exit ☐ Follow-up

Intervention Duration (Select one)

- ☐ Single Session Intervention
☐ Multiple Session Brief Intervention (less than 30 day duration)
☐ Multiple Session Long Intervention (30 days or longer duration)

Intervention Name(s) (If the participant is receiving services for more than one intervention, please list each intervention below)

| |
|----|
| 1. |
| 2. |
| 3. |

Section One: Facts About You

First, we'd like to ask some basic questions about you. Your answers will not be used to identify you in any way. Instead, your answers will help us understand how different groups (like men or women, or people of similar ages) feel about substance abuse and HIV prevention.

1. How would you describe yourself? (Gender)

- ☐ Male
☐ Female
☐ Transgender
 ☐ Male to female
 ☐ Female to male

2. In what year were you born? (Enter all four digits of the year in the boxes below, and fill in corresponding circles)

| | | | |
|-------------------------|-------------------------|-------------------------|-------------------------|
| | | | |
| 1 <input type="radio"/> | 0 <input type="radio"/> | 0 <input type="radio"/> | 0 <input type="radio"/> |
| 2 <input type="radio"/> | 1 <input type="radio"/> | 1 <input type="radio"/> | 1 <input type="radio"/> |
| | 2 <input type="radio"/> | 2 <input type="radio"/> | 2 <input type="radio"/> |
| | 3 <input type="radio"/> | 3 <input type="radio"/> | 3 <input type="radio"/> |
| | 4 <input type="radio"/> | 4 <input type="radio"/> | 4 <input type="radio"/> |
| | 5 <input type="radio"/> | 5 <input type="radio"/> | 5 <input type="radio"/> |
| | 6 <input type="radio"/> | 6 <input type="radio"/> | 6 <input type="radio"/> |
| | 7 <input type="radio"/> | 7 <input type="radio"/> | 7 <input type="radio"/> |
| | 8 <input type="radio"/> | 8 <input type="radio"/> | 8 <input type="radio"/> |
| | 9 <input type="radio"/> | 9 <input type="radio"/> | 9 <input type="radio"/> |

3. In what month were you born?

- ☐ January ☐ May ☐ September
☐ February ☐ June ☐ October
☐ March ☐ July ☐ November
☐ April ☐ August ☐ December

4. On what day of the month were you born?

- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="radio"/> 1 | <input type="radio"/> 12 | <input type="radio"/> 22 |
| <input type="radio"/> 2 | <input type="radio"/> 13 | <input type="radio"/> 23 |
| <input type="radio"/> 3 | <input type="radio"/> 14 | <input type="radio"/> 24 |
| <input type="radio"/> 4 | <input type="radio"/> 15 | <input type="radio"/> 25 |
| <input type="radio"/> 5 | <input type="radio"/> 16 | <input type="radio"/> 26 |
| <input type="radio"/> 6 | <input type="radio"/> 17 | <input type="radio"/> 27 |
| <input type="radio"/> 7 | <input type="radio"/> 18 | <input type="radio"/> 28 |
| <input type="radio"/> 8 | <input type="radio"/> 19 | <input type="radio"/> 29 |
| <input type="radio"/> 9 | <input type="radio"/> 20 | <input type="radio"/> 30 |
| <input type="radio"/> 10 | <input type="radio"/> 21 | <input type="radio"/> 31 |
| <input type="radio"/> 11 | | |

5. Are you Hispanic or Latino?

- ☐ Yes
☐ No

6. **What is your race?** (Select one or more)

- ☐ White
- ☐ Black or African American
- ☐ American Indian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ Alaska Native
- ☐ Other

7. **How would you describe yourself?**
(Sexual orientation)

- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Gay or lesbian
- ☐ Unsure

8. **What is your primary spoken language?**

- ☐ English
- ☐ Spanish
- ☐ Asian (Chinese, Japanese, or other)
- ☐ American Indian (Apache, Blackfoot, Navajo, or other)
- ☐ Other

9. **How long have you lived in the United States?**

- ☐ Less than a year
- ☐ 1 to 2 years
- ☐ 3 to 4 years
- ☐ 5 or more years
- ☐ All my life

10. **What is the highest level of education you have finished, whether or not you received a degree?** (Mark the highest grade you have completed.)

- | | |
|--|--|
| <input type="radio"/> 1 st grade | <input type="radio"/> College freshman |
| <input type="radio"/> 2 nd grade | <input type="radio"/> College sophomore |
| <input type="radio"/> 3 rd grade | <input type="radio"/> College junior |
| <input type="radio"/> 4 th grade | <input type="radio"/> College completion |
| <input type="radio"/> 5 th grade | <input type="radio"/> Some graduate school, but no degree received |
| <input type="radio"/> 6 th grade | <input type="radio"/> Master's degree |
| <input type="radio"/> 7 th grade | <input type="radio"/> Some professional school, (such as medical or law school) but no degree received or doctoral program |
| <input type="radio"/> 8 th grade | <input type="radio"/> Doctorate or professional degree |
| <input type="radio"/> 9 th grade | |
| <input type="radio"/> 10 th grade | |
| <input type="radio"/> 11 th grade | |
| <input type="radio"/> 12 th grade | |

11. **If less than 12 years of education, do you have a GED (General Equivalency Diploma)?**

- ☐ Yes
- ☐ No

12. **Have you completed a technical or trade school program (such as beautician, cosmetology, business, appliance repair, computer etc.)?**

- ☐ Yes
- ☐ No

13. **Which of the following best describes you?**
(Mark the one that fits best)

- ☐ Employed full time (35+ hours per week)
- ☐ Employed part time
- ☐ Unemployed (looking for work)
- ☐ Unemployed (disabled)
- ☐ Unemployed (volunteer work)
- ☐ Unemployed (retired)
- ☐ Unemployed (full-time student)
- ☐ Unemployed (full-time homemaker)
- ☐ Unemployed (other reason)

14. **During the past 12 months, have you driven a vehicle while you were under the influence of alcohol?**

- ☐ Yes
- ☐ No
- ☐ Don't know or can't say

15. **Have you ever been in juvenile/adult detention, jail, or prison for more than 3 days?**

- ☐ Yes
- ☐ No

16. **If YES to question 15, how long has it been since you last got out of juvenile/adult detention, jail, or prison?**

- ☐ Never in juvenile/adult detention, jail, or prison for more than 3 days
- ☐ Fewer than 30 days
- ☐ Between 30 days and 1 year
- ☐ Between 1 and 2 years
- ☐ Between 2 and 3 years
- ☐ Between 3 and 4 years
- ☐ Between 4 and 5 years
- ☐ More than 5 years

End of Section One

Section Two: Attitudes & Knowledge

Next, we'd like to ask you how you feel about substance use and sexual behavior, as well as what you know about HIV/AIDS. Again, your answers are private and will not be used to identify you.

The next few questions ask about HOW MUCH you think people RISK HARMING themselves physically or in other ways by using alcohol, tobacco, and drugs.

17. How much do people risk harming themselves physically or in other ways when they smoke one or more packs of cigarettes per day?

☐ No risk
☐ Slight risk
☐ Moderate risk
☐ Great risk
☐ Don't know or can't say

18. How much do people risk harming themselves physically or in other ways when they smoke marijuana once or twice a week?

☐ No risk
☐ Slight risk
☐ Moderate risk
☐ Great risk
☐ Don't know or can't say

19. How much do people risk harming themselves physically or in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?

☐ No risk
☐ Slight risk
☐ Moderate risk
☐ Great risk
☐ Don't know or can't say

The next questions are about your beliefs and attitudes toward **SEX**.

Some of the questions ask about having sex. By *sex* or *sexual activity*, we mean a situation where two partners get sexually excited or aroused (turned on) by touching each other's genitals (penis or vagina) or anus (butt) with their own genitals, hands, or mouth.

When a male inserts his penis into his female partner's vagina, the partners are considered to be having *vaginal sex*.

When one partner's mouth is in contact with the other partner's genitals (penis or vagina) or anus during sex, the partners are considered to be having *oral sex*.

When a male's penis is inserted into his male or female partner's anus, the partners are considered to be having *anal sex*.

Some questions ask about *sexual partners*. A sexual partner is someone with whom you have sex, that is, engage in sexual activity.

Some questions refer to *protected sex* and *unprotected sex*. Protected sex is when a latex or polyurethane condom (rubber) is used to cover the penis; a female condom is used to cover the vagina; or a dental dam is used to cover the anus. By unprotected sex, we mean vaginal, oral, or anal sex without a barrier such as a condom or dental dam.

How much do you think people risk harming themselves physically:

20. If they have oral sex without a condom or dental dam?

☐ No risk
☐ Slight risk
☐ Moderate risk
☐ Great risk

21. If they have vaginal sex without a condom?

- ☐ No risk
- ☐ Slight risk
- ☐ Moderate risk
- ☐ Great risk

22. If they have anal sex without a condom?

- ☐ No risk
- ☐ Slight risk
- ☐ Moderate risk
- ☐ Great risk

23. If they have sex under the influence of alcohol?

- ☐ No risk
- ☐ Slight risk
- ☐ Moderate risk
- ☐ Great risk

24. If they have sex while high on drugs?

- ☐ No risk
- ☐ Slight risk
- ☐ Moderate risk
- ☐ Great risk

25. If they share nonsanitized needles or works when using drugs? (-Worksll refer to supplies used for injecting drugs)

- ☐ No risk
- ☐ Slight risk
- ☐ Moderate risk
- ☐ Great risk

The next questions ask more about your attitudes and beliefs about sex.

In your relationship with your **PRIMARY (MAIN) partner**, how confident are you that you could:

26. Refuse to have sex with your partner because you weren't in the mood?

- ☐ Not at all
- ☐ A little
- ☐ Somewhat
- ☐ Very much

27. Ask your partner to wait while you got a condom or dental dam?

- ☐ Not at all
- ☐ A little
- ☐ Somewhat
- ☐ Very much

28. Tell your partner how to treat you sexually?

- ☐ Not at all
- ☐ A little
- ☐ Somewhat
- ☐ Very much

29. Refuse to engage in sexual practices you didn't like?

- ☐ Not at all
- ☐ A little
- ☐ Somewhat
- ☐ Very much

30. Ask your partner to use a condom or dental dam?

- ☐ Not at all
- ☐ A little
- ☐ Somewhat
- ☐ Very much

31. Refuse to have sex because your partner did not want to use a condom or dental dam?

- ☐ Not at all
- ☐ A little
- ☐ Somewhat
- ☐ Very much

The next set of questions ask how likely you are to do certain behaviors in the future.

In the **next 6 months**, how likely are you...

32. To drink five or more alcoholic drinks in one sitting?

- ☐ Not at all likely
- ☐ A little likely
- ☐ Somewhat likely
- ☐ Very likely

33. To use any illegal drugs (including prescription drugs) to get high?

- ☐ Not at all likely
- ☐ A little likely
- ☐ Somewhat likely
- ☐ Very likely

34. To use injection drugs without a doctor's orders, just to feel good or to get high?

- ☐ Not at all likely
- ☐ A little likely
- ☐ Somewhat likely
- ☐ Very likely

35. To use clean needles when injecting drugs?

- ☐ I do not use injected drugs
- ☐ Not at all likely
- ☐ A little likely
- ☐ Somewhat likely
- ☐ Very likely

36. To practice safe sex?

- ☐ Not intending to have sex during the next 6 months
- ☐ Not at all likely
- ☐ A little likely
- ☐ Somewhat likely
- ☐ Very likely

HIV/AIDS – What You Know

Please indicate whether you think each of the following statements about HIV/AIDS is true or false, or if you don't know.

37. Only people who look sick can spread the HIV/AIDS virus.

- ☐ True
- ☐ False
- ☐ Don't know

38. Only people who have sexual intercourse with gay (homosexual) people get HIV/AIDS.

- ☐ True
- ☐ False
- ☐ Don't know

39. Birth control pills protect women from getting the HIV/AIDS virus.

- ☐ True
- ☐ False
- ☐ Don't know

40. There are drugs available to treat HIV that can lengthen the life of a person infected with the virus.

- ☐ True
- ☐ False
- ☐ Don't know

41. There is no cure for AIDS.

- ☐ True
- ☐ False
- ☐ Don't know

42. Young people under age 18 need their parents' permission to get an HIV test.

- ☐ True
- ☐ False
- ☐ Don't know

The next questions ask about health care services.

43. Would you know where to go in your neighborhood to see a health care professional regarding HIV/AIDS or other sexually transmitted health issues?

- ☐ Yes
- ☐ No

44. Would you know where to go in your neighborhood to see a health care professional regarding a drug or alcohol problem?

- ☐ Yes
- ☐ No

45. Have you ever been tested for the HIV virus that causes AIDS?

- ☐ Yes
- ☐ No

46. If **YES** to Question 45, what type of HIV test was it?

- ☐ Never tested for HIV/AIDS
- ☐ Oral (Mouth) test (OraSure/OraQuick Rapid Saliva Test or other)
- ☐ Urine test
- ☐ Blood test in a clinic or doctor's office (Western Block or other)
- ☐ More than one test conducted in a clinic or doctor's office
- ☐ Home test kit
- ☐ Don't know

47. If **YES** to question 45, did you receive or go back to get your results?

- ☐ Never tested for HIV/AIDS
- ☐ Yes
- ☐ No

The following questions ask about your relationships.

Thinking about all the people you know...

48. Are there any people you could go to when you want to talk about things having to do with your own health?
- ☐ Yes, there are people I can talk with
 - ☐ No, there is no one I can talk with
49. Are there any people you could talk with about personal issues having to do with sex?
- ☐ Yes, there are people I can talk with
 - ☐ No, there is no one I can talk with
50. Are there any people you could talk with about personal issues having to do with alcohol or drug use?
- ☐ Yes, there are people I can talk with
 - ☐ No, there is no one I can talk with
51. Are there certain people you could go to if you need to talk about other personal matters that you wouldn't tell just anyone?
- ☐ Yes, there are people I can talk with
 - ☐ No, there is no one I can talk with

The next few questions ask about your religious or spiritual beliefs and how they may affect your daily life.

52. In general, how important are religious or spiritual beliefs in your day-to-day life?
- ☐ Not at all important
 - ☐ Not too important
 - ☐ Fairly important
 - ☐ Very important
53. When you have problems or difficulties with your school (education), work, family, friends, or personal life, how often do you seek spiritual guidance and support?
- ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Often
 - ☐ Almost always
54. How spiritual or religious would you say you are?
- ☐ Not spiritual or religious at all
 - ☐ Not too spiritual or religious
 - ☐ Fairly spiritual or religious
 - ☐ Very spiritual or religious

End of Section Two

Section Three: Behavior & Relationships

Cigarettes, Alcohol and Drugs

The next two questions are about **CIGARETTES and OTHER TOBACCO PRODUCTS**.

Think back over the past 30 days and record on how many days, if any, you used cigarettes and/or other tobacco products.

55. During the past 30 days, on how many days did you smoke part or all of a **cigarette**? (Includes menthol and regular cigarettes and loose tobacco rolled into cigarettes)

| | | |
|-------------------------------|-------------------------------|------------------------------------|
| <input type="radio"/> 0 days | <input type="radio"/> 12 days | <input type="radio"/> 24 days |
| <input type="radio"/> 1 day | <input type="radio"/> 13 days | <input type="radio"/> 25 days |
| <input type="radio"/> 2 days | <input type="radio"/> 14 days | <input type="radio"/> 26 days |
| <input type="radio"/> 3 days | <input type="radio"/> 15 days | <input type="radio"/> 27 days |
| <input type="radio"/> 4 days | <input type="radio"/> 16 days | <input type="radio"/> 28 days |
| <input type="radio"/> 5 days | <input type="radio"/> 17 days | <input type="radio"/> 29 days |
| <input type="radio"/> 6 days | <input type="radio"/> 18 days | <input type="radio"/> 30 days |
| <input type="radio"/> 7 days | <input type="radio"/> 19 days | <input type="radio"/> Don't know |
| <input type="radio"/> 8 days | <input type="radio"/> 20 days | <input type="radio"/> or can't say |
| <input type="radio"/> 9 days | <input type="radio"/> 21 days | |
| <input type="radio"/> 10 days | <input type="radio"/> 22 days | |
| <input type="radio"/> 11 days | <input type="radio"/> 23 days | |

56. During the past 30 days, on how many days did you use **other tobacco products**? (Includes any tobacco product other than cigarettes such as snuff, chewing tobacco, and smoking tobacco from a pipe)

| | | |
|-------------------------------|-------------------------------|------------------------------------|
| <input type="radio"/> 0 days | <input type="radio"/> 12 days | <input type="radio"/> 24 days |
| <input type="radio"/> 1 day | <input type="radio"/> 13 days | <input type="radio"/> 25 days |
| <input type="radio"/> 2 days | <input type="radio"/> 14 days | <input type="radio"/> 26 days |
| <input type="radio"/> 3 days | <input type="radio"/> 15 days | <input type="radio"/> 27 days |
| <input type="radio"/> 4 days | <input type="radio"/> 16 days | <input type="radio"/> 28 days |
| <input type="radio"/> 5 days | <input type="radio"/> 17 days | <input type="radio"/> 29 days |
| <input type="radio"/> 6 days | <input type="radio"/> 18 days | <input type="radio"/> 30 days |
| <input type="radio"/> 7 days | <input type="radio"/> 19 days | <input type="radio"/> Don't know |
| <input type="radio"/> 8 days | <input type="radio"/> 20 days | <input type="radio"/> or can't say |
| <input type="radio"/> 9 days | <input type="radio"/> 21 days | |
| <input type="radio"/> 10 days | <input type="radio"/> 22 days | |
| <input type="radio"/> 11 days | <input type="radio"/> 23 days | |

The next two questions are about **ALCOHOL**. By alcohol, we mean BEER, WINE, WINE COOLERS, MALT BEVERAGES or HARD LIQUOR.

Different groups of people in the United States may use alcohol for religious reasons. For example, some churches serve wine during a church service. If you drink wine at church or for some other religious reason, **do not** count these times in your answers to the questions below.

Think back over the past 30 days and record on how many days, if any, you consumed alcohol.

57. During the past 30 days, on how many days did you drink one or more drinks of an **alcoholic beverage**?

| | | |
|-------------------------------|-------------------------------|------------------------------------|
| <input type="radio"/> 0 days | <input type="radio"/> 12 days | <input type="radio"/> 24 days |
| <input type="radio"/> 1 day | <input type="radio"/> 13 days | <input type="radio"/> 25 days |
| <input type="radio"/> 2 days | <input type="radio"/> 14 days | <input type="radio"/> 26 days |
| <input type="radio"/> 3 days | <input type="radio"/> 15 days | <input type="radio"/> 27 days |
| <input type="radio"/> 4 days | <input type="radio"/> 16 days | <input type="radio"/> 28 days |
| <input type="radio"/> 5 days | <input type="radio"/> 17 days | <input type="radio"/> 29 days |
| <input type="radio"/> 6 days | <input type="radio"/> 18 days | <input type="radio"/> 30 days |
| <input type="radio"/> 7 days | <input type="radio"/> 19 days | <input type="radio"/> Don't know |
| <input type="radio"/> 8 days | <input type="radio"/> 20 days | <input type="radio"/> or can't say |
| <input type="radio"/> 9 days | <input type="radio"/> 21 days | |
| <input type="radio"/> 10 days | <input type="radio"/> 22 days | |
| <input type="radio"/> 11 days | <input type="radio"/> 23 days | |

58. During the past 30 days, on how many days have you been **drunk or very high** from drinking alcoholic beverages?

| | | |
|-------------------------------|-------------------------------|------------------------------------|
| <input type="radio"/> 0 days | <input type="radio"/> 12 days | <input type="radio"/> 24 days |
| <input type="radio"/> 1 day | <input type="radio"/> 13 days | <input type="radio"/> 25 days |
| <input type="radio"/> 2 days | <input type="radio"/> 14 days | <input type="radio"/> 26 days |
| <input type="radio"/> 3 days | <input type="radio"/> 15 days | <input type="radio"/> 27 days |
| <input type="radio"/> 4 days | <input type="radio"/> 16 days | <input type="radio"/> 28 days |
| <input type="radio"/> 5 days | <input type="radio"/> 17 days | <input type="radio"/> 29 days |
| <input type="radio"/> 6 days | <input type="radio"/> 18 days | <input type="radio"/> 30 days |
| <input type="radio"/> 7 days | <input type="radio"/> 19 days | <input type="radio"/> Don't know |
| <input type="radio"/> 8 days | <input type="radio"/> 20 days | <input type="radio"/> or can't say |
| <input type="radio"/> 9 days | <input type="radio"/> 21 days | |
| <input type="radio"/> 10 days | <input type="radio"/> 22 days | |
| <input type="radio"/> 11 days | <input type="radio"/> 23 days | |

The next question is about **MARIJUANA or HASHISH**. Marijuana is sometimes called weed, blunt, hydro, grass, or pot. Hashish is sometimes called hash or hash oil.

Think back over the past 30 days and record on how many days, if any, you used marijuana or hashish.

59. During the past 30 days, on how many days did you use marijuana or hashish?

- | | | |
|-------------------------------|-------------------------------|------------------------------------|
| <input type="radio"/> 0 days | <input type="radio"/> 12 days | <input type="radio"/> 24 days |
| <input type="radio"/> 1 day | <input type="radio"/> 13 days | <input type="radio"/> 25 days |
| <input type="radio"/> 2 days | <input type="radio"/> 14 days | <input type="radio"/> 26 days |
| <input type="radio"/> 3 days | <input type="radio"/> 15 days | <input type="radio"/> 27 days |
| <input type="radio"/> 4 days | <input type="radio"/> 16 days | <input type="radio"/> 28 days |
| <input type="radio"/> 5 days | <input type="radio"/> 17 days | <input type="radio"/> 29 days |
| <input type="radio"/> 6 days | <input type="radio"/> 18 days | <input type="radio"/> 30 days |
| <input type="radio"/> 7 days | <input type="radio"/> 19 days | <input type="radio"/> Don't know |
| <input type="radio"/> 8 days | <input type="radio"/> 20 days | <input type="radio"/> or can't say |
| <input type="radio"/> 9 days | <input type="radio"/> 21 days | |
| <input type="radio"/> 10 days | <input type="radio"/> 22 days | |
| <input type="radio"/> 11 days | <input type="radio"/> 23 days | |

The next question is about **OTHER ILLEGAL DRUGS**, excluding marijuana or hashish.

These include substances like inhalants or sniffed substances such as glue, gasoline, paint thinner, cleaning fluid, or shoe polish (used to feel good or get high), heroin, crack, or cocaine, methamphetamine, hallucinogens (drugs that cause people to see or experience things that are not real) such as LSD (sometimes called acid), Ecstasy (MDMA), PCP, peyote (sometimes called angel dust), and prescription drugs used without a doctor's orders, just to feel good or to get high.

Think back over the past 30 days and record on how many days, if any, you used other illegal drugs.

60. During the past 30 days, on how many days did you use any other illegal drug?

- | | | |
|-------------------------------|-------------------------------|------------------------------------|
| <input type="radio"/> 0 days | <input type="radio"/> 12 days | <input type="radio"/> 24 days |
| <input type="radio"/> 1 day | <input type="radio"/> 13 days | <input type="radio"/> 25 days |
| <input type="radio"/> 2 days | <input type="radio"/> 14 days | <input type="radio"/> 26 days |
| <input type="radio"/> 3 days | <input type="radio"/> 15 days | <input type="radio"/> 27 days |
| <input type="radio"/> 4 days | <input type="radio"/> 16 days | <input type="radio"/> 28 days |
| <input type="radio"/> 5 days | <input type="radio"/> 17 days | <input type="radio"/> 29 days |
| <input type="radio"/> 6 days | <input type="radio"/> 18 days | <input type="radio"/> 30 days |
| <input type="radio"/> 7 days | <input type="radio"/> 19 days | <input type="radio"/> Don't know |
| <input type="radio"/> 8 days | <input type="radio"/> 20 days | <input type="radio"/> or can't say |
| <input type="radio"/> 9 days | <input type="radio"/> 21 days | |
| <input type="radio"/> 10 days | <input type="radio"/> 22 days | |
| <input type="radio"/> 11 days | <input type="radio"/> 23 days | |

Now we would like to ask about your use of several specific drugs during the past 30 days.

61. During the past 30 days, on how many days did you use cocaine or crack?

- | | | |
|-------------------------------|-------------------------------|------------------------------------|
| <input type="radio"/> 0 days | <input type="radio"/> 12 days | <input type="radio"/> 24 days |
| <input type="radio"/> 1 day | <input type="radio"/> 13 days | <input type="radio"/> 25 days |
| <input type="radio"/> 2 days | <input type="radio"/> 14 days | <input type="radio"/> 26 days |
| <input type="radio"/> 3 days | <input type="radio"/> 15 days | <input type="radio"/> 27 days |
| <input type="radio"/> 4 days | <input type="radio"/> 16 days | <input type="radio"/> 28 days |
| <input type="radio"/> 5 days | <input type="radio"/> 17 days | <input type="radio"/> 29 days |
| <input type="radio"/> 6 days | <input type="radio"/> 18 days | <input type="radio"/> 30 days |
| <input type="radio"/> 7 days | <input type="radio"/> 19 days | <input type="radio"/> Don't know |
| <input type="radio"/> 8 days | <input type="radio"/> 20 days | <input type="radio"/> or can't say |
| <input type="radio"/> 9 days | <input type="radio"/> 21 days | |
| <input type="radio"/> 10 days | <input type="radio"/> 22 days | |
| <input type="radio"/> 11 days | <input type="radio"/> 23 days | |

62. During the past 30 days, on how many days did you use methamphetamine? (Also called meth, crystal meth, crank, go, and speed)

- | | | |
|-------------------------------|-------------------------------|------------------------------------|
| <input type="radio"/> 0 days | <input type="radio"/> 12 days | <input type="radio"/> 24 days |
| <input type="radio"/> 1 day | <input type="radio"/> 13 days | <input type="radio"/> 25 days |
| <input type="radio"/> 2 days | <input type="radio"/> 14 days | <input type="radio"/> 26 days |
| <input type="radio"/> 3 days | <input type="radio"/> 15 days | <input type="radio"/> 27 days |
| <input type="radio"/> 4 days | <input type="radio"/> 16 days | <input type="radio"/> 28 days |
| <input type="radio"/> 5 days | <input type="radio"/> 17 days | <input type="radio"/> 29 days |
| <input type="radio"/> 6 days | <input type="radio"/> 18 days | <input type="radio"/> 30 days |
| <input type="radio"/> 7 days | <input type="radio"/> 19 days | <input type="radio"/> Don't know |
| <input type="radio"/> 8 days | <input type="radio"/> 20 days | <input type="radio"/> or can't say |
| <input type="radio"/> 9 days | <input type="radio"/> 21 days | |
| <input type="radio"/> 10 days | <input type="radio"/> 22 days | |
| <input type="radio"/> 11 days | <input type="radio"/> 23 days | |

63. During the past 30 days, on how many days have you used prescription drugs without a doctor's orders, in order to feel good or to get high?

- | | | |
|-------------------------------|-------------------------------|------------------------------------|
| <input type="radio"/> 0 days | <input type="radio"/> 12 days | <input type="radio"/> 24 days |
| <input type="radio"/> 1 day | <input type="radio"/> 13 days | <input type="radio"/> 25 days |
| <input type="radio"/> 2 days | <input type="radio"/> 14 days | <input type="radio"/> 26 days |
| <input type="radio"/> 3 days | <input type="radio"/> 15 days | <input type="radio"/> 27 days |
| <input type="radio"/> 4 days | <input type="radio"/> 16 days | <input type="radio"/> 28 days |
| <input type="radio"/> 5 days | <input type="radio"/> 17 days | <input type="radio"/> 29 days |
| <input type="radio"/> 6 days | <input type="radio"/> 18 days | <input type="radio"/> 30 days |
| <input type="radio"/> 7 days | <input type="radio"/> 19 days | <input type="radio"/> Don't know |
| <input type="radio"/> 8 days | <input type="radio"/> 20 days | <input type="radio"/> or can't say |
| <input type="radio"/> 9 days | <input type="radio"/> 21 days | |
| <input type="radio"/> 10 days | <input type="radio"/> 22 days | |
| <input type="radio"/> 11 days | <input type="radio"/> 23 days | |

64. During the past 30 days, on how many days have you injected any drugs? (Count only injections without a doctor's orders you used to feel good or to get high.)

- | | | |
|-------------------------------|-------------------------------|------------------------------------|
| <input type="radio"/> 0 days | <input type="radio"/> 12 days | <input type="radio"/> 24 days |
| <input type="radio"/> 1 day | <input type="radio"/> 13 days | <input type="radio"/> 25 days |
| <input type="radio"/> 2 days | <input type="radio"/> 14 days | <input type="radio"/> 26 days |
| <input type="radio"/> 3 days | <input type="radio"/> 15 days | <input type="radio"/> 27 days |
| <input type="radio"/> 4 days | <input type="radio"/> 16 days | <input type="radio"/> 28 days |
| <input type="radio"/> 5 days | <input type="radio"/> 17 days | <input type="radio"/> 29 days |
| <input type="radio"/> 6 days | <input type="radio"/> 18 days | <input type="radio"/> 30 days |
| <input type="radio"/> 7 days | <input type="radio"/> 19 days | <input type="radio"/> Don't know |
| <input type="radio"/> 8 days | <input type="radio"/> 20 days | <input type="radio"/> or can't say |
| <input type="radio"/> 9 days | <input type="radio"/> 21 days | |
| <input type="radio"/> 10 days | <input type="radio"/> 22 days | |
| <input type="radio"/> 11 days | <input type="radio"/> 23 days | |

65. During the past 30 days, how stressful have things been for you because of your use of alcohol or drugs?

- ☐ I have not used alcohol or drugs in the past 30 days
- ☐ Not at all
- ☐ Somewhat
- ☐ Considerably
- ☐ Extremely

66. During the past 30 days, has your use of alcohol or drugs caused you to have emotional problems?

- ☐ I have not used alcohol or drugs in the past 30 days
- ☐ Not at all
- ☐ Somewhat
- ☐ Considerably
- ☐ Extremely

The next few questions ask about the **FIRST TIME** you used a substance.

Think back whether you have EVER used any substances. If so, what was your age the FIRST TIME you used the following substances.

67. How old were you the first time you smoked part or all of a cigarette? (Includes menthol and regular cigarettes and loose tobacco rolled into cigarettes)

- ☐ I have never smoked part or all of a cigarette
- | | |
|--|------------------------------------|
| <input type="radio"/> 5 years old or younger | <input type="radio"/> 20 years old |
| <input type="radio"/> 6 years old | <input type="radio"/> 21 years old |
| <input type="radio"/> 7 years old | <input type="radio"/> 22 years old |
| <input type="radio"/> 8 years old | <input type="radio"/> 23 years old |
| <input type="radio"/> 9 years old | <input type="radio"/> 24 years old |
| <input type="radio"/> 10 years old | <input type="radio"/> 25 years old |
| <input type="radio"/> 11 years old | <input type="radio"/> 26 years old |
| <input type="radio"/> 12 years old | <input type="radio"/> 27 years old |
| <input type="radio"/> 13 years old | <input type="radio"/> 28 years old |
| <input type="radio"/> 14 years old | <input type="radio"/> 29 years old |
| <input type="radio"/> 15 years old | <input type="radio"/> 30 years old |
| <input type="radio"/> 16 years old | <input type="radio"/> Over 30 |
| <input type="radio"/> 17 years old | <input type="radio"/> years old |
| <input type="radio"/> 18 years old | <input type="radio"/> Don't know |
| <input type="radio"/> 19 years old | <input type="radio"/> or can't say |

68. How old were you the first time you used any other tobacco product? (Includes any tobacco product other than cigarettes such as snuff, chewing tobacco, and smoking tobacco from a pipe)

- ☐ I have never used any other tobacco products
- | | |
|--|------------------------------------|
| <input type="radio"/> 5 years old or younger | <input type="radio"/> 20 years old |
| <input type="radio"/> 6 years old | <input type="radio"/> 21 years old |
| <input type="radio"/> 7 years old | <input type="radio"/> 22 years old |
| <input type="radio"/> 8 years old | <input type="radio"/> 23 years old |
| <input type="radio"/> 9 years old | <input type="radio"/> 24 years old |
| <input type="radio"/> 10 years old | <input type="radio"/> 25 years old |
| <input type="radio"/> 11 years old | <input type="radio"/> 26 years old |
| <input type="radio"/> 12 years old | <input type="radio"/> 27 years old |
| <input type="radio"/> 13 years old | <input type="radio"/> 28 years old |
| <input type="radio"/> 14 years old | <input type="radio"/> 29 years old |
| <input type="radio"/> 15 years old | <input type="radio"/> 30 years old |
| <input type="radio"/> 16 years old | <input type="radio"/> Over 30 |
| <input type="radio"/> 17 years old | <input type="radio"/> years old |
| <input type="radio"/> 18 years old | <input type="radio"/> Don't know |
| <input type="radio"/> 19 years old | <input type="radio"/> or can't say |

69. How old were you the first time you had a drink of an alcoholic beverage? (Includes beer, wine, wine coolers, malt beverages, and liquor) DO NOT include any time when you only had a sip or two from a drink.

- ☐ I have never had a drink of an alcoholic beverage
- | | |
|--|---|
| <input type="radio"/> 5 years old or younger | <input type="radio"/> 20 years old |
| <input type="radio"/> 6 years old | <input type="radio"/> 21 years old |
| <input type="radio"/> 7 years old | <input type="radio"/> 22 years old |
| <input type="radio"/> 8 years old | <input type="radio"/> 23 years old |
| <input type="radio"/> 9 years old | <input type="radio"/> 24 years old |
| <input type="radio"/> 10 years old | <input type="radio"/> 25 years old |
| <input type="radio"/> 11 years old | <input type="radio"/> 26 years old |
| <input type="radio"/> 12 years old | <input type="radio"/> 27 years old |
| <input type="radio"/> 13 years old | <input type="radio"/> 28 years old |
| <input type="radio"/> 14 years old | <input type="radio"/> 29 years old |
| <input type="radio"/> 15 years old | <input type="radio"/> 30 years old |
| <input type="radio"/> 16 years old | <input type="radio"/> Over 30 years old |
| <input type="radio"/> 17 years old | <input type="radio"/> Don't know or can't say |
| <input type="radio"/> 18 years old | |
| <input type="radio"/> 19 years old | |

70. How old were you the first time you used marijuana or hashish? (Also known as grass, pot, hash, or hash oil)

- ☐ I have never used marijuana or hashish
- | | |
|--|---|
| <input type="radio"/> 5 years old or younger | <input type="radio"/> 20 years old |
| <input type="radio"/> 6 years old | <input type="radio"/> 21 years old |
| <input type="radio"/> 7 years old | <input type="radio"/> 22 years old |
| <input type="radio"/> 8 years old | <input type="radio"/> 23 years old |
| <input type="radio"/> 9 years old | <input type="radio"/> 24 years old |
| <input type="radio"/> 10 years old | <input type="radio"/> 25 years old |
| <input type="radio"/> 11 years old | <input type="radio"/> 26 years old |
| <input type="radio"/> 12 years old | <input type="radio"/> 27 years old |
| <input type="radio"/> 13 years old | <input type="radio"/> 28 years old |
| <input type="radio"/> 14 years old | <input type="radio"/> 29 years old |
| <input type="radio"/> 15 years old | <input type="radio"/> 30 years old |
| <input type="radio"/> 16 years old | <input type="radio"/> Over 30 years old |
| <input type="radio"/> 17 years old | <input type="radio"/> Don't know or can't say |
| <input type="radio"/> 18 years old | |
| <input type="radio"/> 19 years old | |

71. How old were you the first time you used any other illegal drug?

- ☐ I have never used any other illegal drugs
- | | |
|--|---|
| <input type="radio"/> 5 years old or younger | <input type="radio"/> 20 years old |
| <input type="radio"/> 6 years old | <input type="radio"/> 21 years old |
| <input type="radio"/> 7 years old | <input type="radio"/> 22 years old |
| <input type="radio"/> 8 years old | <input type="radio"/> 23 years old |
| <input type="radio"/> 9 years old | <input type="radio"/> 24 years old |
| <input type="radio"/> 10 years old | <input type="radio"/> 25 years old |
| <input type="radio"/> 11 years old | <input type="radio"/> 26 years old |
| <input type="radio"/> 12 years old | <input type="radio"/> 27 years old |
| <input type="radio"/> 13 years old | <input type="radio"/> 28 years old |
| <input type="radio"/> 14 years old | <input type="radio"/> 29 years old |
| <input type="radio"/> 15 years old | <input type="radio"/> 30 years old |
| <input type="radio"/> 16 years old | <input type="radio"/> Over 30 years old |
| <input type="radio"/> 17 years old | <input type="radio"/> Don't know or can't say |
| <input type="radio"/> 18 years old | |
| <input type="radio"/> 19 years old | |

Sexual Behavior

Now we'd like to ask you about your experience with sex. If you cannot remember what we mean by sex, please refer to the definitions on page 4. Remember, your answers are private.

72. Have you ever had sex (either vaginal, oral, or anal)?

- ☐ Yes
☐ No

73. Have you had oral sex in the past 30 days?

- ☐ Yes
☐ No

74. The last time you had oral sex, was it protected or unprotected?

- ☐ I have never had oral sex
- ☐ Protected
☐ Unprotected

75. Have you had vaginal sex in the past 30 days?

- ☐ Yes
☐ No

76. The last time you had vaginal sex, was it protected or unprotected?

- ☐ I have never had vaginal sex
- ☐ Protected
- ☐ Unprotected

77. Have you had anal sex in the past 30 days?

- ☐ Yes
- ☐ No

78. The last time you had anal sex, was it protected or unprotected?

- ☐ I have never had anal sex
- ☐ Protected
- ☐ Unprotected

The next set of questions asks more specifically about your sexual behavior. Some questions refer to the past 3 months and others to your experience ever.

79. In the past 3 months, have you had sex with any men?

- ☐ Yes
- ☐ No

80. Are you a woman who has sex with men?

- ☐ Yes
- ☐ No

81. Are you a man who has sex with men?

- ☐ Yes
- ☐ No

82. In the past 3 months, have you had sex with any women?

- ☐ Yes
- ☐ No

83. Are you a man who has sex with women?

- ☐ Yes
- ☐ No

84. Are you a woman who has sex with women?

- ☐ Yes
- ☐ No

85. During the past 3 months, how many sexual partners have you had?

- ☐ None
- ☐ 1 person
- ☐ 2 people
- ☐ 3 people
- ☐ 4 people
- ☐ 5 people
- ☐ 6 people
- ☐ 7 people
- ☐ 8 people
- ☐ 9 people
- ☐ 10 people or more

86. Have you ever had unprotected sex (vaginal, anal, or oral) with someone in exchange for money, drugs, or shelter?

- ☐ Yes
- ☐ No

87. In the past 3 months, have you had unprotected sex (vaginal, anal, or oral) with someone in exchange for money, drugs, or shelter?

- ☐ Yes
- ☐ No

88. Have you ever had unprotected sex (vaginal, anal, or oral) with a partner you know had, or suspected of having a sexually transmitted disease (STD)?

- ☐ Yes
- ☐ No

89. In the past 3 months, have you had unprotected sex (vaginal, anal, or oral) with a partner you know had, or suspected of having a sexually transmitted disease (STD)?

- ☐ Yes
- ☐ No

90. Have you ever had unprotected sex (vaginal, anal, or oral) with a partner you know had, or suspected of having HIV/AIDS?

- ☐ Yes
- ☐ No

91. In the past 3 months, have you had unprotected sex (vaginal, anal, or oral) with a partner you know had, or suspected of having HIV/AIDS?

- ☐ Yes
- ☐ No

92. Have you ever had unprotected sex (vaginal, anal, or oral) with someone whom you knew was, or suspected of being an injected drug user?

- ☐ Yes
- ☐ No

93. In the past 3 months, have you had unprotected sex (vaginal, anal, or oral) with someone whom you knew was, or suspected of being an injected drug user?

- ☐ Yes
- ☐ No

94. Have you ever had sex while you were under the influence of drugs or alcohol?

- ☐ Yes
- ☐ No

95. In the past 3 months, have you had sex while you were under the influence of drugs or alcohol?

- ☐ Yes
- ☐ No

The next few questions ask about abuse you might have experienced.

In the past 3 months, how often has anyone with whom you had an intimate relation, sexual or not...

96. Emotionally abused you (swore at you, called you negative names, kept you from seeing family or friends)?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

97. Physically abused you (slapped, beat, kicked, or choked you; threatened you with a knife or a gun)?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

98. Sexually abused you (forced you to have sex, physically hurt the sexual parts of your body)?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

99. Forced you to use drugs or alcohol?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

Family, Relationships and Work

100. Describe your current relationship status.

- ☐ Single (never married)
- ☐ Informally married or living with a permanent partner
- ☐ Legally married
- ☐ Separated
- ☐ Divorced or broken up from an informal marriage
- ☐ Widowed

101. With whom do you live?
(Mark all that apply)

- ☐ Alone
- ☐ With my mother
- ☐ With my father
- ☐ With my brother(s) and/or sister(s)
- ☐ With my grandparent(s)
- ☐ With other relatives or guardian
- ☐ With my spouse or significant other
- ☐ With my child or my children
- ☐ With roommates
- ☐ Other

102. Describe where you live.

- ☐ In my own home or apartment
- ☐ In a relative's home
- ☐ In a group home
- ☐ In a foster home
- ☐ Homeless or in a shelter
- ☐ Other

103. At what age did you have your first child?

- ☐ No children
- ☐ 9 to 13 years old
- ☐ 14 to 18 years old
- ☐ 19 to 25 years old
- ☐ 26 to 34 years old
- ☐ 35 years old or older

104. How many children under the age of 18 are living with you?

- ☐ 0
- ☐ 1 to 2
- ☐ 3 to 4
- ☐ 5 to 6
- ☐ More than 6

105. If you have children, during the past 12 months, how many times have you talked with your children about the dangers or problems associated with the use of tobacco, alcohol, or drugs?

- ☐ I don't have any children
- ☐ 0 times
- ☐ 1 to 2 times
- ☐ A few times
- ☐ Many times
- ☐ Don't know or can't say

106. Think about the household members that live with you right now. About how much income have you and/or your family members made in the last year before taxes? (Include child support and/or cash payments from the government, for example, welfare [TANF], SSI, or unemployment compensation)

- ☐ \$0–\$10,000
- ☐ \$10,001–\$20,000
- ☐ \$20,001–\$30,000
- ☐ \$30,001–\$40,000
- ☐ \$40,001–\$50,000
- ☐ \$50,001–\$60,000
- ☐ More than \$60,000

107. Do you have health care or medical insurance?

- ☐ Yes
- ☐ No

108. Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you? (Mark one)

- ☐ More likely
- ☐ Less likely
- ☐ Would make no difference
- ☐ Don't know or can't say

The next set of questions asks about your family's relationships.

109. I'm available when others in my family want to talk to me.

- ☐ I don't have any family
- ☐ Not true
- ☐ Sometimes true
- ☐ Usually true
- ☐ Always true

110. I listen to what other family members have to say, even when I disagree.

- ☐ I don't have any family
- ☐ Not true
- ☐ Sometimes true
- ☐ Usually true
- ☐ Always true

111. Members of my family ask each other for help.

- ☐ I don't have any family
- ☐ Not true
- ☐ Sometimes true
- ☐ Usually true
- ☐ Always true

112. Members of my family like to spend free time with each other.

- ☐ I don't have any family
- ☐ Not true
- ☐ Sometimes true
- ☐ Usually true
- ☐ Always true

113. Members of my family feel very close to each other.

- ☐ I don't have any family
- ☐ Not true
- ☐ Sometimes true
- ☐ Usually true
- ☐ Always true

114. We can easily think of things to do together as a family.

- ☐ I don't have any family
- ☐ Not true
- ☐ Sometimes true
- ☐ Usually true
- ☐ Always true

The next two questions ask about programs or classes you may have attended recently.

115. In the past 30 days, have you been in any classes or programs where they talked about prevention of drug or alcohol abuse?

- ☐ Yes
- ☐ No

116. In the past 30 days, have you been in any classes or programs where they talked about preventing HIV/AIDS?

- ☐ Yes
- ☐ No

The last two questions ask about your experience with this survey.

117. How comfortable was it for you to answer the questions in this survey?

- ☐ Very comfortable
- ☐ Somewhat comfortable
- ☐ Somewhat uncomfortable
- ☐ Very uncomfortable

118. How truthful were you when answering the questions?

- ☐ Very truthful
- ☐ Somewhat truthful
- ☐ Somewhat untruthful
- ☐ Very untruthful

YOU ARE DONE!
Thank you for your help!


Appendix G

Intervention Recruitment Flyers

The SISTA PROJECT
"For Black women, by Black women"

OFFICE OF
RESEARCH SUBJECTS PROTECTION
MAY 12 2011

Join us for discussions about relationships, dating,
and healthy choices.



For more information, please call:
Raymond Tademy, Ph.D. (rhtademy@vcu.edu)
Deborah Butler, M.I.S. (dsbutler@vcu.edu)
Center for Cultural Experiences In Prevention
Virginia Commonwealth University
(804) 828 - 6261

*Please leave a call back number, a message, and best time to return your call

Participants will receive up to a total of \$50 for their participation in this project

V-1 5-10-2011

APPROVED
G-B-11 / RV / JSC

NIA
A Raise 5 Project
"For Black men, by Black men"

OFFICE OF
RESEARCH SUBJECTS PROTECTION
MAY 12 2011



Join us for discussions about relationships, dating,
and healthy choices.

For more information, please call:
Raymond Tademy, Ph.D. (rhtademy@vcu.edu)
Deborah Butler, M.I.S. (dsbutler@vcu.edu)
Center for Cultural Experiences In Prevention
Virginia Commonwealth University
(804) 828 - 6261

*Please leave a call back number, a message, and best time to return your call

Participants will receive up to a total of \$50 in for their participation in this project

V-1 5-10-2011

APPROVED
G-B-11 / RV / JSC

Safe in the City

A Raise 5 Project
"For Black men and women"



**Join us for discussions about relationships, dating,
and healthy choices.**

For more information, please call:

Raymond Tadey, Ph.D. (rhtadey@vcu.edu)
Deborah Butler, M.I.S. (dsbutler@vcu.edu)
Center for Cultural Experiences in Prevention
Virginia Commonwealth University
(804) 828 - 6261

*Please leave a call back number, a message, and best time to return your call

Participants will receive up to a total of \$30 for their participation in this project

V-1 5-10-2011

APPROVED

6-8-11 / DE / JZ

National College Health Survey

211

Health, Health Education and Safety

1. How would you describe your general health?

☐ Excellent
 ☐ Very good
 ☐ Good
 ☐ Fair
 ☐ Poor
 ☐ Don't know

(Please mark the appropriate column for each question to the right)

Alcohol and other drug use

Cold/Flu/Sore throat

Depression/Anxiety

Eating disorders

Grief and loss

How to help others in distress

Injury prevention

Nutrition

Physical activity

Pregnancy prevention

Problem use of Internet/computer games

Relationship difficulties

Sexual assault/Relationship violence prevention

Sexually transmitted disease/infection (STD/I) prevention

Sleep difficulties

Stress reduction

Suicide prevention

Tobacco use

Violence prevention

2. Have you received information on the following topics from your college or university?

No

Yes

3. Are you interested in receiving information on the following topics from your college or university?

No

Yes

4. Within the last 12 months, how often did you:

(Please mark the appropriate column for each row)

N/A, did not do this activity within the last 12 months

Wear a seatbelt when you rode in a car?

Wear a helmet when you rode a bicycle?

Wear a helmet when you rode a motorcycle?

Wear a helmet when you were inline skating?

Always
 Most of the time
 Sometimes
 Rarely
 Never

5. Within the last 12 months:

(Please mark the appropriate column for each row)

Were you in a physical fight?

Were you physically assaulted (do not include sexual assault)?

Were you verbally threatened?

Were you sexually touched without your consent?

Was sexual penetration attempted (vaginal, anal, oral) without your consent?

Were you sexually penetrated (vaginal, anal, oral) without your consent?

Were you a victim of stalking (e.g., waiting for you outside your classroom, residence, or office; repeated emails/phone calls)?

Yes
 No

PAGE TWO

365 spine.pdf

7. How safe do you feel:

(Please mark the appropriate column for each row)

| | very safe | Somewhat safe | Somewhat unsafe | Not safe at all |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| On this campus (daytime)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| On this campus (nighttime)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| In the community surrounding this school (daytime)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| In the community surrounding this school (nighttime)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

| | | | | |
|--|---|---|-----------------------|-----------------------|
| 8. | Within the last 30 days, on how many days did you use: | | 3-5 days | 6-9 days |
| | | Have used, but not in last 30 days | 1-2 days | 10-19 days |
| | (Please mark the appropriate column for each row) | Never used | | 20-29 days |
| | | | | Used daily |
| Cigarettes | | | <input type="radio"/> | <input type="radio"/> |
| Tobacco from a water pipe (hookah) | | | <input type="radio"/> | <input type="radio"/> |
| Cigars, little cigars, clove cigarettes | | | <input type="radio"/> | <input type="radio"/> |
| Smokeless tobacco | | | <input type="radio"/> | <input type="radio"/> |
| Alcohol (beer, wine, liquor) | | | <input type="radio"/> | <input type="radio"/> |
| Marijuana (pot, weed, hashish, hash oil) | | | <input type="radio"/> | <input type="radio"/> |
| Cocaine (crack, rock, freebase) | | | <input type="radio"/> | <input type="radio"/> |
| Methamphetamine (crystal meth, ice, crank) | | | <input type="radio"/> | <input type="radio"/> |
| Other amphetamines (diet pills, bennies) | | | <input type="radio"/> | <input type="radio"/> |
| Sedatives (downers, ludes) | | | <input type="radio"/> | <input type="radio"/> |
| Hallucinogens (LSD, PCP) | | | <input type="radio"/> | <input type="radio"/> |
| Anabolic steroids (Testosterone) | | | <input type="radio"/> | <input type="radio"/> |
| Opiates (heroin, smack) | | | <input type="radio"/> | <input type="radio"/> |
| Inhalants (glue, solvents, gas) | | | <input type="radio"/> | <input type="radio"/> |
| MDMA (Ecstasy) | | | <input type="radio"/> | <input type="radio"/> |
| Other club drugs (GHB, Ketamine, Rohypnol) | | | <input type="radio"/> | <input type="radio"/> |
| Other illegal drugs | | | <input type="radio"/> | <input type="radio"/> |

9. Within the last 30 days, how often do you think the typical student at your school used:

(State your best estimate; Please mark the appropriate column for each row)

Have used, but not in last 30 days
Never used
3-5 days
1-2 days
6-9 days
10-19 days
20-29 days
Used daily

| | | | | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Cigarettes | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Tobacco from a water pipe (hookah) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cigars, little cigars, clove cigarettes | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Smokeless tobacco | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Alcohol (beer, wine, liquor) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Marijuana (pot, weed, hashish, hash oil) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cocaine (crack, rock, freebase) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Methamphetamine (crystal meth, ice, crank) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other amphetamines (diet pills, bennies) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Sedatives (downers, ludes) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hallucinogens (LSD, PCP) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Anabolic steroids (Testosterone) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Opiates (heroin, smack) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Inhalants (glue, solvents, gas) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| MDMA (Ecstasy) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other club drugs (GHB, Ketamine, Rohypnol) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other illegal drugs | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

One drink of alcohol is defined as a 12 oz. can or bottle of beer or wine cooler, a 4 oz. glass of wine, or a shot of liquor straight or in a mixed drink.

10. The last time you "partied"/socialized how many drinks of alcohol did you have? (If you did not drink alcohol, please enter 00. If less than 10, enter 01, 02, 03, etc.)

| | |
|---|-----|
| D | |
| R | |
| I | 0 1 |
| N | 1 1 |
| K | 2 2 |
| S | 3 3 |
| | 4 4 |
| | 5 5 |
| | 6 6 |
| | 7 7 |
| | 8 8 |
| | 9 9 |

11. The last time you "partied"/socialized over how many hours did you drink alcohol? (If you did not drink alcohol, please enter 00. If less than 10, enter 01, 02, 03, etc.)

| | |
|---|-----|
| H | |
| O | |
| U | 0 1 |
| R | 1 1 |
| S | 2 2 |
| | 3 3 |
| | 4 4 |
| | 5 5 |
| | 6 6 |
| | 7 7 |
| | 8 8 |
| | 9 9 |

12. How many drinks of alcohol do you think the typical student at your school had the last time he/she "partied"/socialized? (If you think the typical student at your school does not drink alcohol, please enter 00. If less than 10, enter 01, 02, 03, etc.)

| | |
|---|-----|
| D | |
| R | |
| I | 0 1 |
| N | 1 1 |
| K | 2 2 |
| S | 3 3 |
| | 4 4 |
| | 5 5 |
| | 6 6 |
| | 7 7 |
| | 8 8 |
| | 9 9 |

13. Over the last two weeks, how many times have you had five or more drinks of alcohol at a sitting?

- ☐ N/A, don't drink ☐ 2 times ☐ 5 times ☐ 8 times
☐ None ☐ 3 times ☐ 6 times ☐ 9 times
☐ 1 time ☐ 4 times ☐ 7 times ☐ 10 or more times

14. Within the last 30 days, did you:

(Please mark the appropriate column for each row)

Yes
No
N/A, don't drink
N/A, don't drive

| | | | | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| Drive after drinking any alcohol at all | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Drive after drinking five or more drinks of alcohol | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

15. During the last 12 months, when you "partied"/socialized, how often did you:

(Please mark the appropriate column for each row)

| | N/A, don't drink | Rarely Never | Sometimes Most of the time Always |
|---|-----------------------|-----------------------|---|
| Alternate non-alcoholic with alcoholic beverages | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Avoid drinking games | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Choose not to drink alcohol | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Determine, in advance, not to exceed a set number of drinks | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Eat before and/or during drinking | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Have a friend let you know when you have had enough | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Keep track of how many drinks you were having | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pace your drinks to 1 or fewer per hour | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Stay with the same group of friends the entire time you were drinking | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Stick with only one kind of alcohol when drinking | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Use a designated driver | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

16. Within the last 12 months, have you experienced any of the following when drinking alcohol?

(Please mark the appropriate column for each row)

| | N/A, don't drink | Yes No |
|--|-----------------------|-----------------------|
| Did something you later regretted | <input type="radio"/> | <input type="radio"/> |
| Forgot where you were or what you did | <input type="radio"/> | <input type="radio"/> |
| Got in trouble with the police | <input type="radio"/> | <input type="radio"/> |
| Someone had sex with me without my consent | <input type="radio"/> | <input type="radio"/> |
| Had sex with someone without their consent | <input type="radio"/> | <input type="radio"/> |
| Had unprotected sex | <input type="radio"/> | <input type="radio"/> |
| Physically injured yourself | <input type="radio"/> | <input type="radio"/> |
| Physically injured another person | <input type="radio"/> | <input type="radio"/> |
| Seriously considered suicide | <input type="radio"/> | <input type="radio"/> |

17. Within the last 30 days, what percent of students at your school used:
State your best estimate. (If less than 10, please enter 00, 01, 02, etc.)

| Cigarettes % Used | Alcohol % Used | Marijuana % Used |
|--|--|--|
| <input type="radio"/> 0 <input type="radio"/> 10 | <input type="radio"/> 0 <input type="radio"/> 10 | <input type="radio"/> 0 <input type="radio"/> 10 |
| <input type="radio"/> 1 <input type="radio"/> 11 | <input type="radio"/> 1 <input type="radio"/> 11 | <input type="radio"/> 1 <input type="radio"/> 11 |
| <input type="radio"/> 2 <input type="radio"/> 21 | <input type="radio"/> 2 <input type="radio"/> 21 | <input type="radio"/> 2 <input type="radio"/> 21 |
| <input type="radio"/> 3 <input type="radio"/> 31 | <input type="radio"/> 3 <input type="radio"/> 31 | <input type="radio"/> 3 <input type="radio"/> 31 |
| <input type="radio"/> 4 <input type="radio"/> 41 | <input type="radio"/> 4 <input type="radio"/> 41 | <input type="radio"/> 4 <input type="radio"/> 41 |
| <input type="radio"/> 5 <input type="radio"/> 51 | <input type="radio"/> 5 <input type="radio"/> 51 | <input type="radio"/> 5 <input type="radio"/> 51 |
| <input type="radio"/> 6 <input type="radio"/> 61 | <input type="radio"/> 6 <input type="radio"/> 61 | <input type="radio"/> 6 <input type="radio"/> 61 |
| <input type="radio"/> 7 <input type="radio"/> 71 | <input type="radio"/> 7 <input type="radio"/> 71 | <input type="radio"/> 7 <input type="radio"/> 71 |
| <input type="radio"/> 8 <input type="radio"/> 81 | <input type="radio"/> 8 <input type="radio"/> 81 | <input type="radio"/> 8 <input type="radio"/> 81 |
| <input type="radio"/> 9 <input type="radio"/> 91 | <input type="radio"/> 9 <input type="radio"/> 91 | <input type="radio"/> 9 <input type="radio"/> 91 |
| <input type="radio"/> 10 <input type="radio"/> 101 | <input type="radio"/> 10 <input type="radio"/> 101 | <input type="radio"/> 10 <input type="radio"/> 101 |

18. Within the last 12 months, have you taken any of the following prescription drugs that were not prescribed to you?

(Please mark the appropriate column for each row)

| | Yes No |
|---|-----------------------|
| Antidepressants (e.g., Celexa, Lexapro, Prozac, Wellbutrin, Zoloft) | <input type="radio"/> |
| Erectile dysfunction drugs (e.g., Viagra, Cialis, Levitra) | <input type="radio"/> |
| Pain killers (e.g., OxyContin, Vicodin, Codeine) | <input type="radio"/> |
| Sedatives (e.g., Xanax, Valium) | <input type="radio"/> |
| Stimulants (e.g., Ritalin, Adderall) | <input type="radio"/> |

PAGE FIVE

PLEASE DO NOT WRITE IN THIS AREA



SERIAL #

Sex Behavior and Contraception

19. Within the last 12 months, with how many partners have you had oral sex, vaginal intercourse, or anal intercourse? (If you did not have a sex partner within the last 12 months, please enter 00. If less than 10, enter 01, 02, 03, etc.)

P
A
R
T
N
E
R
S

| | |
|----|----|
| 0 | 1 |
| 2 | 3 |
| 4 | 5 |
| 6 | 7 |
| 8 | 9 |
| 10 | 11 |
| 12 | 13 |
| 14 | 15 |
| 16 | 17 |
| 18 | 19 |
| 20 | 21 |

20. Within last 12 months, did you have sexual partner(s) who were:

(Please mark the appropriate column for each row)

| | Yes | No |
|-------------|-----------------------|-----------------------|
| Female | <input type="radio"/> | <input type="radio"/> |
| Male | <input type="radio"/> | <input type="radio"/> |
| Transgender | <input type="radio"/> | <input type="radio"/> |

21. Within the last 30 days, did you have:

(Please mark the appropriate column for each row)

| | Yes | No, have done this sexual activity in the past but not in the last 30 days | No, have never done this sexual activity |
|----------------------|-----------------------|--|--|
| Oral sex? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Vaginal intercourse? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Anal intercourse? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

22. Within the last 30 days, how often did you or your partner(s) use a condom or other protective barrier (e.g., male condom, female condom, dam, glove) during:

(Please mark the appropriate column for each row)

| | Have not done this sexual activity during the last 30 days | N/A, never did this sexual activity | Never | Rarely | Sometimes | Most of the time | Always | CONDOM/BARRIER USE |
|----------------------|--|-------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Oral sex? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Vaginal intercourse? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Anal intercourse? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

23A. Did you or your partner use a method of birth control to prevent pregnancy the last time you had vaginal intercourse?

- ☐ Yes (continue to item 23B)
- ☐ N/A, have not had vaginal intercourse (skip to item 24)
- ☐ No, have not had vaginal intercourse that could result in a pregnancy (skip to item 24)
- ☐ No, did not want to prevent pregnancy (skip to item 24)
- ☐ No, did not use any birth control method (skip to item 24)
- ☐ Don't know (skip to item 24)

23B. Please indicate whether or not you or your partner used each of the following methods of birth control to prevent pregnancy the last time you had vaginal intercourse. (Please mark the appropriate column for each row)

| | Yes | No | | Yes | No |
|---|-----------------------|-----------------------|--|-----------------------|-----------------------|
| Birth control pills (monthly or extended cycle) | <input type="radio"/> | <input type="radio"/> | Diaphragm or cervical cap | <input type="radio"/> | <input type="radio"/> |
| Birth control shots | <input type="radio"/> | <input type="radio"/> | Contraceptive sponge | <input type="radio"/> | <input type="radio"/> |
| Birth control implants | <input type="radio"/> | <input type="radio"/> | Spermicide (e.g., foam, jelly, cream) | <input type="radio"/> | <input type="radio"/> |
| Birth control patch | <input type="radio"/> | <input type="radio"/> | Fertility awareness (e.g., calendar, mucous, basal body temperature) | <input type="radio"/> | <input type="radio"/> |
| Vaginal ring | <input type="radio"/> | <input type="radio"/> | Withdrawal | <input type="radio"/> | <input type="radio"/> |
| Intrauterine device (IUD) | <input type="radio"/> | <input type="radio"/> | Sterilization (e.g., hysterectomy, tubes tied, or vasectomy) | <input type="radio"/> | <input type="radio"/> |
| Male condom | <input type="radio"/> | <input type="radio"/> | Other method | <input type="radio"/> | <input type="radio"/> |
| Female condom | <input type="radio"/> | <input type="radio"/> | | | |

PAGE SIX

24. Within the last 12 months, have you or your partner(s) used emergency contraception ("morning after pill")?

- ☐ N/A, have not had vaginal intercourse in the last 12 months
- ☐ No
- ☐ Yes
- ☐ Don't know

25. Within the last 12 months, have you or your partner(s) become pregnant?

- ☐ N/A, have not had vaginal intercourse in the last 12 months
- ☐ No
- ☐ Yes, unintentionally
- ☐ Yes, intentionally
- ☐ Don't know

Weight, Nutrition, and Exercise

26. How do you describe your weight?

- ☐ Very underweight
- ☐ Slightly underweight
- ☐ About the right weight
- ☐ Slightly overweight
- ☐ Very overweight

27. Are you trying to do any of the following about your weight?

- ☐ I am not trying to do anything about my weight
- ☐ Stay the same weight
- ☐ Lose weight
- ☐ Gain weight

28. How many servings of fruits and vegetables do you usually have per day?

(1 serving = 1 medium piece of fruit; 1/2 cup fresh, frozen, or canned fruits/vegetables; 3/4 cup fruit/vegetable juice; 1 cup salad greens; or 1/4 cup dried fruit)

- ☐ 0 servings per day
- ☐ 1-2 servings per day
- ☐ 3-4 servings per day
- ☐ 5 or more servings per day

29. On how many of the past 7 days did you:

(Please mark the appropriate column for each row)

| | 0 days | 1 day | 2 days | 3 days | 4 days | 5 days | 6 days | 7 days |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Do moderate-intensity cardio or aerobic exercise (caused a noticeable increase in heart rate, such as a brisk walk) for at least 30 minutes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Do vigorous-intensity cardio or aerobic exercise (caused large increases in breathing or heart rate, such as jogging) for at least 20 minutes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Do 8-10 strength training exercises (such as resistance weight machines) for 8-12 repetitions each? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Mental Health

30. Have you ever:

(Please mark the appropriate column for each row)

| | No, not in last 12 months | No, never | Yes, in the last 2 weeks | Yes, in the last 30 days | Yes, in the last 12 months |
|---|---------------------------|-----------------------|--------------------------|--------------------------|----------------------------|
| Felt things were hopeless | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Felt overwhelmed by all you had to do | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Felt exhausted (not from physical activity) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Felt very lonely | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Felt very sad | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Felt so depressed that it was difficult to function | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Felt overwhelming anxiety | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Felt overwhelming anger | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Intentionally cut, burned, bruised, or otherwise injured yourself | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Seriously considered suicide | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Attempted suicide | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

35. Have you ever received psychological or mental health services from your current college/university's Counseling or Health Service?

☐ No ☐ Yes

36. If in the future you were having a personal problem that was really bothering you, would you consider seeking help from a mental health professional?

☐ No ☐ Yes

37. Within the last 12 months, how would you rate the overall level of stress you have experienced?

☐ No stress
☐ Less than average stress
☐ Average stress
☐ More than average stress
☐ Tremendous stress

Physical Health

38. Within the last 30 days, did you do any of the following?
(Please mark the appropriate column for each row)

| | Yes | No |
|--|-----------------------|-----------------------|
| Exercise to lose weight | <input type="radio"/> | <input type="radio"/> |
| Diet to lose weight | <input type="radio"/> | <input type="radio"/> |
| Vomit or take laxatives to lose weight | <input type="radio"/> | <input type="radio"/> |
| Take diet pills to lose weight | <input type="radio"/> | <input type="radio"/> |

39. Have you:
(Please mark the appropriate column for each row)

| | Don't know | Yes | No |
|--|-----------------------|-----------------------|-----------------------|
| Had a dental exam and cleaning in the last 12 months? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| (Males) Performed testicular self exam in the last 30 days? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| (Females) Performed breast self exam in the last 30 days? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| (Females) Had a routine gynecological exam in the last 12 months? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Used sunscreen regularly with sun exposure? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Ever been tested for Human Immunodeficiency Virus (HIV) infection? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

40. Have you received the following vaccinations (shots)?
(Please mark the appropriate column for each row)

| | Don't know | Yes | No |
|--|-----------------------|-----------------------|-----------------------|
| Hepatitis B | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Human Papillomavirus/HPV (cervical cancer vaccine) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Influenza (the flu) in the last 12 months (shot or nasal mist) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Measles, Mumps, Rubella | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Meningococcal disease (meningococcal meningitis) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Varicella (chicken pox) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

| (Please mark the appropriate column for each row) | Yes No | | Yes No |
|---|---|--|---|
| Allergies | <input type="checkbox"/> <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> <input type="checkbox"/> | High cholesterol | <input type="checkbox"/> <input type="checkbox"/> |
| Back pain | <input type="checkbox"/> <input type="checkbox"/> | Human Immunodeficiency Virus (HIV) | <input type="checkbox"/> <input type="checkbox"/> |
| Broken bone/Fracture/Sprain | <input type="checkbox"/> <input type="checkbox"/> | Irritable Bowel Syndrome (IBS) | <input type="checkbox"/> <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> <input type="checkbox"/> | Migraine headache | <input type="checkbox"/> <input type="checkbox"/> |
| Chlamydia | <input type="checkbox"/> <input type="checkbox"/> | Mononucleosis | <input type="checkbox"/> <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> <input type="checkbox"/> | Pelvic Inflammatory Disease (PID) | <input type="checkbox"/> <input type="checkbox"/> |
| Ear infection | <input type="checkbox"/> <input type="checkbox"/> | Repetitive stress injury (e.g., carpal tunnel syndrome) | <input type="checkbox"/> <input type="checkbox"/> |
| Endometriosis | <input type="checkbox"/> <input type="checkbox"/> | Sinus infection | <input type="checkbox"/> <input type="checkbox"/> |
| Genital herpes | <input type="checkbox"/> <input type="checkbox"/> | Strep throat | <input type="checkbox"/> <input type="checkbox"/> |
| Genital warts/Human Papillomavirus (HPV) | <input type="checkbox"/> <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> |
| Gonorrhea | <input type="checkbox"/> <input type="checkbox"/> | Urinary tract infection | <input type="checkbox"/> <input type="checkbox"/> |
| Hepatitis B or C | <input type="checkbox"/> <input type="checkbox"/> | | |

| (Please mark the appropriate column for each row) | 2 days | | 3 days | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| | 1 day | 0 days | 6 days | 7 days |
| Awakened too early in the morning and couldn't get back to sleep? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Felt tired, dragged out, or sleepy during the day? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Gone to bed because you just could not stay awake any longer? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Had an extremely hard time falling asleep? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

Impediments to Academic Performance

(Please select the most serious outcome for each item below)

Significant disruption in thesis, dissertation, research, or practicum work
Received an incomplete or dropped the course
Received a lower grade in the course
Received a lower grade on an exam or important project
I have experienced this issue but my academics have not been affected
This did not happen to me/not applicable

45. Within the last 12 months, have any of the following affected your academic performance?

| | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Alcohol use | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Allergies | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Anxiety | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Assault (physical) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Assault (sexual) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Attention Deficit and Hyperactivity Disorder (ADHD) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cold/Flu/Sore throat | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Concern for a troubled friend or family member | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Chronic health problem or serious illness (e.g., diabetes, asthma, cancer) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Chronic pain | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Death of a friend or family member | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Depression | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Discrimination (e.g., homophobia, racism, sexism) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Drug use | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Eating disorder/problem | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Finances | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Gambling | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Homesickness | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Injury (fracture, sprain, strain, cut) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Internet use/computer games | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Learning disability | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Participation in extracurricular activities (e.g., campus clubs, organizations, athletics) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pregnancy (yours or your partner's) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Relationship difficulties | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Roommate difficulties | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Sexually transmitted disease/infection (STD/I) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Sinus infection/Ear infection/Bronchitis/Strep throat | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Sleep difficulties | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Stress | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Work | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other (please specify _____) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Demographic Characteristics

| | | | | | | |
|--------------------------|---|---|------|------|--------------------------------------|--------|
| 46. How old are you? → | Years | 49. What is your height in feet and inches? → | Feet | Inch | 50. What is your weight in pounds? → | Pounds |
| 47. What is your gender? | <input type="radio"/> 01 <input type="radio"/> 02 <input type="radio"/> 03 <input type="radio"/> 04 <input type="radio"/> 05 <input type="radio"/> 06 <input type="radio"/> 07 <input type="radio"/> 08 <input type="radio"/> 09 <input type="radio"/> 10 <input type="radio"/> 11 <input type="radio"/> 12 <input type="radio"/> 13 <input type="radio"/> 14 <input type="radio"/> 15 <input type="radio"/> 16 <input type="radio"/> 17 <input type="radio"/> 18 <input type="radio"/> 19 <input type="radio"/> 20 <input type="radio"/> 21 <input type="radio"/> 22 <input type="radio"/> 23 <input type="radio"/> 24 <input type="radio"/> 25 <input type="radio"/> 26 <input type="radio"/> 27 <input type="radio"/> 28 <input type="radio"/> 29 <input type="radio"/> 30 <input type="radio"/> 31 <input type="radio"/> 32 <input type="radio"/> 33 <input type="radio"/> 34 <input type="radio"/> 35 <input type="radio"/> 36 <input type="radio"/> 37 <input type="radio"/> 38 <input type="radio"/> 39 <input type="radio"/> 40 <input type="radio"/> 41 <input type="radio"/> 42 <input type="radio"/> 43 <input type="radio"/> 44 <input type="radio"/> 45 <input type="radio"/> 46 <input type="radio"/> 47 <input type="radio"/> 48 <input type="radio"/> 49 <input type="radio"/> 50 <input type="radio"/> 51 <input type="radio"/> 52 <input type="radio"/> 53 <input type="radio"/> 54 <input type="radio"/> 55 <input type="radio"/> 56 <input type="radio"/> 57 <input type="radio"/> 58 <input type="radio"/> 59 <input type="radio"/> 60 <input type="radio"/> 61 <input type="radio"/> 62 <input type="radio"/> 63 <input type="radio"/> 64 <input type="radio"/> 65 <input type="radio"/> 66 <input type="radio"/> 67 <input type="radio"/> 68 <input type="radio"/> 69 <input type="radio"/> 70 <input type="radio"/> 71 <input type="radio"/> 72 <input type="radio"/> 73 <input type="radio"/> 74 <input type="radio"/> 75 <input type="radio"/> 76 <input type="radio"/> 77 <input type="radio"/> 78 <input type="radio"/> 79 <input type="radio"/> 80 <input type="radio"/> 81 <input type="radio"/> 82 <input type="radio"/> 83 <input type="radio"/> 84 <input type="radio"/> 85 <input type="radio"/> 86 <input type="radio"/> 87 <input type="radio"/> 88 <input type="radio"/> 89 <input type="radio"/> 90 <input type="radio"/> 91 <input type="radio"/> 92 <input type="radio"/> 93 <input type="radio"/> 94 <input type="radio"/> 95 <input type="radio"/> 96 <input type="radio"/> 97 <input type="radio"/> 98 <input type="radio"/> 99 <input type="radio"/> 100 <input type="radio"/> 101 <input type="radio"/> 102 <input type="radio"/> 103 <input type="radio"/> 104 <input type="radio"/> 105 <input type="radio"/> 106 <input type="radio"/> 107 <input type="radio"/> 108 <input type="radio"/> 109 <input type="radio"/> 110 <input type="radio"/> 111 <input type="radio"/> 112 <input type="radio"/> 113 <input type="radio"/> 114 <input type="radio"/> 115 <input type="radio"/> 116 <input type="radio"/> 117 <input type="radio"/> 118 <input type="radio"/> 119 <input type="radio"/> 120 <input type="radio"/> 121 <input type="radio"/> 122 <input type="radio"/> 123 <input type="radio"/> 124 <input type="radio"/> 125 <input type="radio"/> 126 <input type="radio"/> 127 <input type="radio"/> 128 <input type="radio"/> 129 <input type="radio"/> 130 <input type="radio"/> 131 <input type="radio"/> 132 <input type="radio"/> 133 <input type="radio"/> 134 <input type="radio"/> 135 <input type="radio"/> 136 <input type="radio"/> 137 <input type="radio"/> 138 <input type="radio"/> 139 <input type="radio"/> 140 <input type="radio"/> 141 <input type="radio"/> 142 <input type="radio"/> 143 <input type="radio"/> 144 <input type="radio"/> 145 <input type="radio"/> 146 <input type="radio"/> 147 <input type="radio"/> 148 <input type="radio"/> 149 <input type="radio"/> 150 <input type="radio"/> 151 <input type="radio"/> 152 <input type="radio"/> 153 <input type="radio"/> 154 <input type="radio"/> 155 <input type="radio"/> 156 <input type="radio"/> 157 <input type="radio"/> 158 <input type="radio"/> 159 <input type="radio"/> 160 <input type="radio"/> 161 <input type="radio"/> 162 <input type="radio"/> 163 <input type="radio"/> 164 <input type="radio"/> 165 <input type="radio"/> 166 <input type="radio"/> 167 <input type="radio"/> 168 <input type="radio"/> 169 <input type="radio"/> 170 <input type="radio"/> 171 <input type="radio"/> 172 <input type="radio"/> 173 <input type="radio"/> 174 <input type="radio"/> 175 <input type="radio"/> 176 <input type="radio"/> 177 <input type="radio"/> 178 <input type="radio"/> 179 <input type="radio"/> 180 <input type="radio"/> 181 <input type="radio"/> 182 <input type="radio"/> 183 <input type="radio"/> 184 <input type="radio"/> 185 <input type="radio"/> 186 <input type="radio"/> 187 <input type="radio"/> 188 <input type="radio"/> 189 <input type="radio"/> 190 <input type="radio"/> 191 <input type="radio"/> 192 <input type="radio"/> 193 <input type="radio"/> 194 <input type="radio"/> 195 <input type="radio"/> 196 <input type="radio"/> 197 <input type="radio"/> 198 <input type="radio"/> 199 <input type="radio"/> 200 <input type="radio"/> 201 <input type="radio"/> 202 <input type="radio"/> 203 <input type="radio"/> 204 <input type="radio"/> 205 <input type="radio"/> 206 <input type="radio"/> 207 <input type="radio"/> 208 <input type="radio"/> 209 <input type="radio"/> 210 <input type="radio"/> 211 <input type="radio"/> 212 <input type="radio"/> 213 <input type="radio"/> 214 <input type="radio"/> 215 <input type="radio"/> 216 <input type="radio"/> 217 <input type="radio"/> 218 <input type="radio"/> 219 <input type="radio"/> 220 <input type="radio"/> 221 <input type="radio"/> 222 <input type="radio"/> 223 <input type="radio"/> 224 <input type="radio"/> 225 <input type="radio"/> 226 <input type="radio"/> 227 <input type="radio"/> 228 <input type="radio"/> 229 <input type="radio"/> 230 <input type="radio"/> 231 <input type="radio"/> 232 <input type="radio"/> 233 <input type="radio"/> 234 <input type="radio"/> 235 <input type="radio"/> 236 <input type="radio"/> 237 <input type="radio"/> 238 <input type="radio"/> 239 <input type="radio"/> 240 <input type="radio"/> 241 <input type="radio"/> 242 <input type="radio"/> 243 <input type="radio"/> 244 <input type="radio"/> 245 <input type="radio"/> 246 <input type="radio"/> 247 <input type="radio"/> 248 <input type="radio"/> 249 <input type="radio"/> 250 <input type="radio"/> 251 <input type="radio"/> 252 <input type="radio"/> 253 <input type="radio"/> 254 <input type="radio"/> 255 <input type="radio"/> 256 <input type="radio"/> 257 <input type="radio"/> 258 <input type="radio"/> 259 <input type="radio"/> 260 <input type="radio"/> 261 <input type="radio"/> 262 <input type="radio"/> 263 <input type="radio"/> 264 <input type="radio"/> 265 <input type="radio"/> 266 <input type="radio"/> 267 <input type="radio"/> 268 <input type="radio"/> 269 <input type="radio"/> 270 <input type="radio"/> 271 <input type="radio"/> 272 <input type="radio"/> 273 <input type="radio"/> 274 <input type="radio"/> 275 <input type="radio"/> 276 <input type="radio"/> 277 <input type="radio"/> 278 <input type="radio"/> 279 <input type="radio"/> 280 <input type="radio"/> 281 <input type="radio"/> 282 <input type="radio"/> 283 <input type="radio"/> 284 <input type="radio"/> 285 <input type="radio"/> 286 <input type="radio"/> 287 <input type="radio"/> 288 <input type="radio"/> 289 <input type="radio"/> 290 <input type="radio"/> 291 <input type="radio"/> 292 <input type="radio"/> 293 <input type="radio"/> 294 <input type="radio"/> 295 <input type="radio"/> 296 <input type="radio"/> 297 <input type="radio"/> 298 <input type="radio"/> 299 <input type="radio"/> 300 <input type="radio"/> 301 <input type="radio"/> 302 <input type="radio"/> 303 <input type="radio"/> 304 <input type="radio"/> 305 <input type="radio"/> 306 <input type="radio"/> 307 <input type="radio"/> 308 <input type="radio"/> 309 <input type="radio"/> 310 <input type="radio"/> 311 <input type="radio"/> 312 <input type="radio"/> 313 <input type="radio"/> 314 <input type="radio"/> 315 <input type="radio"/> 316 <input type="radio"/> 317 <input type="radio"/> 318 <input type="radio"/> 319 <input type="radio"/> 320 <input type="radio"/> 321 <input type="radio"/> 322 <input type="radio"/> 323 <input type="radio"/> 324 <input type="radio"/> 325 <input type="radio"/> 326 <input type="radio"/> 327 <input type="radio"/> 328 <input type="radio"/> 329 <input type="radio"/> 330 <input type="radio"/> 331 <input type="radio"/> 332 <input type="radio"/> 333 <input type="radio"/> 334 <input type="radio"/> 335 <input type="radio"/> 336 <input type="radio"/> 337 <input type="radio"/> 338 <input type="radio"/> 339 <input type="radio"/> 340 <input type="radio"/> 341 <input type="radio"/> 342 <input type="radio"/> 343 <input type="radio"/> 344 <input type="radio"/> 345 <input type="radio"/> 346 <input type="radio"/> 347 <input type="radio"/> 348 <input type="radio"/> 349 <input type="radio"/> 350 <input type="radio"/> 351 <input type="radio"/> 352 <input type="radio"/> 353 <input type="radio"/> 354 <input type="radio"/> 355 <input type="radio"/> 356 <input type="radio"/> 357 <input type="radio"/> 358 <input type="radio"/> 359 <input type="radio"/> 360 <input type="radio"/> 361 <input type="radio"/> 362 <input type="radio"/> 363 <input type="radio"/> 364 <input type="radio"/> 365 <input type="radio"/> 366 <input type="radio"/> 367 <input type="radio"/> 368 <input type="radio"/> 369 <input type="radio"/> 370 <input type="radio"/> 371 <input type="radio"/> 372 <input type="radio"/> 373 <input type="radio"/> 374 <input type="radio"/> 375 <input type="radio"/> 376 <input type="radio"/> 377 <input type="radio"/> 378 <input type="radio"/> 379 <input type="radio"/> 380 <input type="radio"/> 381 <input type="radio"/> 382 <input type="radio"/> 383 <input type="radio"/> 384 <input type="radio"/> 385 <input type="radio"/> 386 <input type="radio"/> 387 <input type="radio"/> 388 <input type="radio"/> 389 <input type="radio"/> 390 <input type="radio"/> 391 <input type="radio"/> 392 <input type="radio"/> 393 <input type="radio"/> 394 <input type="radio"/> 395 <input type="radio"/> 396 <input type="radio"/> 397 <input type="radio"/> 398 <input type="radio"/> 399 <input type="radio"/> 400 <input type="radio"/> 401 <input type="radio"/> 402 <input type="radio"/> 403 <input type="radio"/> 404 <input type="radio"/> 405 <input type="radio"/> 406 <input type="radio"/> 407 <input type="radio"/> 408 <input type="radio"/> 409 <input type="radio"/> 410 <input type="radio"/> 411 <input type="radio"/> 412 <input type="radio"/> 413 <input type="radio"/> 414 <input type="radio"/> 415 <input type="radio"/> 416 <input type="radio"/> 417 <input type="radio"/> 418 <input type="radio"/> 419 <input type="radio"/> 420 <input type="radio"/> 421 <input type="radio"/> 422 <input type="radio"/> 423 <input type="radio"/> 424 <input type="radio"/> 425 <input type="radio"/> 426 <input type="radio"/> 427 <input type="radio"/> 428 <input type="radio"/> 429 <input type="radio"/> 430 <input type="radio"/> 431 <input type="radio"/> 432 <input type="radio"/> 433 <input type="radio"/> 434 <input type="radio"/> 435 <input type="radio"/> 436 <input type="radio"/> 437 <input type="radio"/> 438 <input type="radio"/> 439 <input type="radio"/> 440 <input type="radio"/> 441 <input type="radio"/> 442 <input type="radio"/> 443 <input type="radio"/> 444 <input type="radio"/> 445 <input type="radio"/> 446 <input type="radio"/> 447 <input type="radio"/> 448 <input type="radio"/> 449 <input type="radio"/> 450 <input type="radio"/> 451 <input type="radio"/> 452 <input type="radio"/> 453 <input type="radio"/> 454 <input type="radio"/> 455 <input type="radio"/> 456 <input type="radio"/> 457 <input type="radio"/> 458 <input type="radio"/> 459 <input type="radio"/> 460 <input type="radio"/> 461 <input type="radio"/> 462 <input type="radio"/> 463 <input type="radio"/> 464 <input type="radio"/> 465 <input type="radio"/> 466 <input type="radio"/> 467 <input type="radio"/> 468 <input type="radio"/> 469 <input type="radio"/> 470 <input type="radio"/> 471 <input type="radio"/> 472 <input type="radio"/> 473 <input type="radio"/> 474 <input type="radio"/> 475 <input type="radio"/> 476 <input type="radio"/> 477 <input type="radio"/> 478 <input type="radio"/> 479 <input type="radio"/> 480 <input type="radio"/> 481 <input type="radio"/> 482 <input type="radio"/> 483 <input type="radio"/> 484 <input type="radio"/> 485 <input type="radio"/> 486 <input type="radio"/> 487 <input type="radio"/> 488 <input type="radio"/> 489 <input type="radio"/> 490 <input type="radio"/> 491 <input type="radio"/> 492 <input type="radio"/> 493 <input type="radio"/> 494 <input type="radio"/> 495 <input type="radio"/> 496 <input type="radio"/> 497 <input type="radio"/> 498 <input type="radio"/> 499 <input type="radio"/> 500 <input type="radio"/> 501 <input type="radio"/> 502 <input type="radio"/> 503 <input type="radio"/> 504 <input type="radio"/> 505 <input type="radio"/> 506 <input type="radio"/> 507 <input type="radio"/> 508 <input type="radio"/> 509 <input type="radio"/> 510 <input type="radio"/> 511 <input type="radio"/> 512 <input type="radio"/> 513 <input type="radio"/> 514 <input type="radio"/> 515 <input type="radio"/> 516 <input type="radio"/> 517 <input type="radio"/> 518 <input type="radio"/> 519 <input type="radio"/> 520 <input type="radio"/> 521 <input type="radio"/> 522 <input type="radio"/> 523 <input type="radio"/> 524 <input type="radio"/> 525 <input type="radio"/> 526 <input type="radio"/> 527 <input type="radio"/> 528 <input type="radio"/> 529 <input type="radio"/> 530 <input type="radio"/> 531 <input type="radio"/> 532 <input type="radio"/> 533 <input type="radio"/> 534 <input type="radio"/> 535 <input type="radio"/> 536 <input type="radio"/> 537 <input type="radio"/> 538 <input type="radio"/> 539 <input type="radio"/> 540 <input type="radio"/> 541 <input type="radio"/> 542 <input type="radio"/> 543 <input type="radio"/> 544 <input type="radio"/> 545 <input type="radio"/> 546 <input type="radio"/> 547 <input type="radio"/> 548 <input type="radio"/> 549 <input type="radio"/> 550 <input type="radio"/> 551 <input type="radio"/> 552 <input type="radio"/> 553 <input type="radio"/> 554 <input type="radio"/> 555 <input type="radio"/> 556 <input type="radio"/> 557 <input type="radio"/> 558 <input type="radio"/> 559 <input type="radio"/> 560 <input type="radio"/> 561 <input type="radio"/> 562 <input type="radio"/> 563 <input type="radio"/> 564 <input type="radio"/> 565 <input type="radio"/> 566 <input type="radio"/> 567 <input type="radio"/> 568 <input type="radio"/> 569 <input type="radio"/> 570 <input type="radio"/> 571 <input type="radio"/> 572 <input type="radio"/> 573 <input type="radio"/> 574 <input type="radio"/> 575 <input type="radio"/> 576 <input type="radio"/> 577 <input type="radio"/> 578 <input type="radio"/> 579 <input type="radio"/> 580 <input type="radio"/> 581 <input type="radio"/> 582 <input type="radio"/> 583 <input type="radio"/> 584 <input type="radio"/> 585 <input type="radio"/> 586 <input type="radio"/> 587 <input type="radio"/> 588 <input type="radio"/> 589 <input type="radio"/> 590 <input type="radio"/> 591 <input type="radio"/> 592 <input type="radio"/> 593 <input type="radio"/> 594 <input type="radio"/> 595 <input type="radio"/> 596 <input type="radio"/> 597 <input type="radio"/> 598 <input type="radio"/> 599 <input type="radio"/> 600 <input type="radio"/> 601 <input type="radio"/> 602 <input type="radio"/> 603 <input type="radio"/> 604 <input type="radio"/> 605 <input type="radio"/> 606 <input type="radio"/> 607 <input type="radio"/> 608 <input type="radio"/> 609 <input type="radio"/> 610 <input type="radio"/> 611 <input type="radio"/> 612 <input type="radio"/> 613 <input type="radio"/> 614 <input type="radio"/> 615 <input type="radio"/> 616 <input type="radio"/> 617 <input type="radio"/> 618 <input type="radio"/> 619 <input type="radio"/> 620 <input type="radio"/> 621 <input type="radio"/> 622 <input type="radio"/> 623 <input type="radio"/> 624 <input type="radio"/> 625 <input type="radio"/> 626 <input type="radio"/> 627 <input type="radio"/> 628 <input type="radio"/> 629 <input type="radio"/> 630 <input type="radio"/> 631 <input type="radio"/> 632 <input type="radio"/> 633 <input type="radio"/> 634 <input type="radio"/> 635 <input type="radio"/> 636 <input type="radio"/> 637 <input type="radio"/> 638 <input type="radio"/> 639 <input type="radio"/> 640 <input type="radio"/> 641 <input type="radio"/> 642 <input type="radio"/> 643 <input type="radio"/> 644 <input type="radio"/> 645 <input type="radio"/> 646 <input type="radio"/> 647 <input type="radio"/> 648 <input type="radio"/> 649 <input type="radio"/> 650 <input type="radio"/> 651 <input type="radio"/> 652 <input type="radio"/> 653 <input type="radio"/> 654 <input type="radio"/> 655 <input type="radio"/> 656 <input type="radio"/> 657 <input type="radio"/> 658 <input type="radio"/> 659 <input type="radio"/> 660 <input type="radio"/> 661 <input type="radio"/> 662 <input type="radio"/> 663 <input type="radio"/> 664 <input type="radio"/> 665 <input type="radio"/> 666 <input type="radio"/> 667 <input type="radio"/> 668 <input type="radio"/> 669 <input type="radio"/> 670 <input type="radio"/> 671 <input type="radio"/> 672 <input type="radio"/> 673 <input type="radio"/> 674 <input type="radio"/> 675 <input type="radio"/> 676 <input type="radio"/> 677 <input type="radio"/> 678 <input type="radio"/> 679 <input type="radio"/> 680 <input type="radio"/> 681 <input type="radio"/> 682 <input type="radio"/> 683 <input type="radio"/> 684 <input type="radio"/> 685 <input type="radio"/> 686 <input type="radio"/> 687 <input type="radio"/> 688 <input type="radio"/> 689 <input type="radio"/> 690 <input type="radio"/> 691 <input type="radio"/> 692 <input type="radio"/> 693 <input type="radio"/> 694 <input type="radio"/> 695 <input type="radio"/> 696 <input type="radio"/> 697 <input type="radio"/> 698 <input type="radio"/> 699 <input type="radio"/> 700 <input type="radio"/> 701 <input type="radio"/> 702 <input type="radio"/> 703 <input type="radio"/> 704 <input type="radio"/> 705 <input type="radio"/> 706 <input type="radio"/> 707 <input type="radio"/> 708 <input type="radio"/> 709 <input type="radio"/> 710 <input type="radio"/> 711 <input type="radio"/> 712 <input type="radio"/> 713 <input type="radio"/> 714 <input type="radio"/> 715 <input type="radio"/> 716 <input type="radio"/> 717 <input type="radio"/> 718 <input type="radio"/> 719 <input type="radio"/> 720 <input type="radio"/> 721 <input type="radio"/> 722 <input type="radio"/> 723 <input type="radio"/> 724 <input type="radio"/> 725 <input type="radio"/> 726 <input type="radio"/> 727 <input type="radio"/> 728 <input type="radio"/> 729 <input type="radio"/> 730 <input type="radio"/> 731 <input type="radio"/> 732 <input type="radio"/> 733 <input type="radio"/> 734 <input type="radio"/> 735 <input type="radio"/> 736 <input type="radio"/> 737 <input type="radio"/> 738 <input type="radio"/> 739 <input type="radio"/> 740 <input type="radio"/> 741 <input type="radio"/> 742 <input type="radio"/> 743 <input type="radio"/> 744 <input type="radio"/> 745 <input type="radio"/> 746 <input type="radio"/> 747 <input type="radio"/> 748 <input type="radio"/> 749 <input type="radio"/> 750 <input type="radio"/> 751 <input type="radio"/> 752 <input type="radio"/> 753 <input type="radio"/> 754 <input type="radio"/> 755 <input type="radio"/> 756 <input type="radio"/> 757 <input type="radio"/> 758 <input type="radio"/> 759 <input type="radio"/> 760 <input type="radio"/> 761 <input type="radio"/> 762 <input type="radio"/> 763 <input type="radio"/> 764 <input type="radio"/> 765 <input type="radio"/> 766 <input type="radio"/> 767 <input type="radio"/> 768 <input type="radio"/> 769 <input type="radio"/> 770 <input type="radio"/> 771 <input type="radio"/> 772 <input type="radio"/> 773 <input type="radio"/> 774 <input type="radio"/> 775 <input type="radio"/> 776 <input type="radio"/> 777 <input type="radio"/> 778 <input type="radio"/> 779 <input type="radio"/> 780 <input type="radio"/> 781 <input type="radio"/> 782 <input type="radio"/> 783 <input type="radio"/> 784 <input type="radio"/> 785 <input type="radio"/> 786 <input type="radio"/> 787 <input type="radio"/> 788 <input type="radio"/> 789 <input type="radio"/> 790 <input type="radio"/> 791 <input type="radio"/> 792 <input type="radio"/> 793 <input type="radio"/> 794 <input type="radio"/> 795 <input type="radio"/> 796 <input type="radio"/> 797 <input type="radio"/> 798 <input type="radio"/> 799 <input type="radio"/> 800 <input type="radio"/> 801 <input type="radio"/> 802 <input type="radio"/> 803 <input type="radio"/> 804 <input type="radio"/> 805 <input type="radio"/> 806 <input type="radio"/> 807 <input type="radio"/> 808 <input type="radio"/> 809 <input type="radio"/> 810 <input type="radio"/> 811 <input type="radio"/> 812 <input type="radio"/> 813 <input type="radio"/> 814 <input type="radio"/> 815 <input type="radio"/> 816 <input type="radio"/> 817 <input type="radio"/> 818 <input type="radio"/> 819 <input type="radio"/> 820 <input type="radio"/> 821 <input type="radio"/> 822 <input type="radio"/> 823 <input type="radio"/> 824 <input type="radio"/> 825 <input type="radio"/> 826 <input type="radio"/> 827 <input type="radio"/> 828 <input type="radio"/> 829 <input type="radio"/> 830 <input type="radio"/> 831 <input type="radio"/> 832 <input type="radio"/> 833 <input type="radio"/> 834 <input type="radio"/> 835 <input type="radio"/> 836 <input type="radio"/> 837 <input type="radio"/> 838 <input type="radio"/> 839 <input type="radio"/> 840 <input type="radio"/> 841 <input type="radio"/> 842 <input type="radio"/> 843 <input type="radio"/> 844 <input type="radio"/> 845 <input type="radio"/> 846 <input type="radio"/> 847 <input type="radio"/> 848 <input type="radio"/> 849 <input type="radio"/> 850 <input type="radio"/> 851 <input type="radio"/> 852 <input type="radio"/> 853 <input type="radio"/> 854 <input type="radio"/> 855 <input type="radio"/> 856 <input type="radio"/> 857 <input type="radio"/> 858 <input type="radio"/> 859 <input type="radio"/> 860 <input type="radio"/> 861 <input type="radio"/> 862 <input type="radio"/> 863 <input type="radio"/> 864 <input type="radio"/> 865 <input type="radio"/> 866 <input type="radio"/> 867 <input type="radio"/> 868 <input type="radio"/> 869 <input type="radio"/> 870 <input type="radio"/> 871 <input type="radio"/> 872 <input type="radio"/> 873 <input type="radio"/> 874 <input type="radio"/> 875 <input type="radio"/> 876 <input type="radio"/> 877 <input type="radio"/> 878 <input type="radio"/> 879 <input type="radio"/> 880 <input type="radio"/> 881 <input type="radio"/> 882 <input type="radio"/> 883 <input type="radio"/> 884 <input type="radio"/> 885 <input type="radio"/> 886 <input type="radio"/> 887 <input type="radio"/> 888 <input type="radio"/> 889 <input type="radio"/> 890 <input type="radio"/> 891 <input type="radio"/> 892 <input type="radio"/> 893 <input type="radio"/> 894 <input type="radio"/> 895 <input type="radio"/> 896 <input type="radio"/> 897 <input type="radio"/> 898 <input type="radio"/> 899 <input type="radio"/> 900 <input type="radio"/> 901 <input type="radio"/> 902 <input type="radio"/> 903 <input type="radio"/> 904 <input type="radio"/> 905 <input type="radio"/> 906 <input type="radio"/> 907 <input type="radio"/> 908 <input type="radio"/> 909 <input type="radio"/> 910 <input type="radio"/> 911 <input type="radio"/> 912 <input type="radio"/> 913 <input type="radio"/> 914 <input type="radio"/> 915 <input type="radio"/> 916 <input type="radio"/> 917 <input type="radio"/> 918 <input type="radio"/> 919 <input type="radio"/> 9 | | | | | |

51. What is your year in school?

52. What is your enrollment status?

53. Have you transferred to this college or university within the last 12 months?

54. How do you usually describe yourself?

(Mark all that apply)

55. Are you an international student?

56. What is your relationship status?

57. What is your marital status?

58. Where do you currently live?

59. Are you a member of a social fraternity or sorority? (e.g., National Interfraternity Conference, National Panhellenic Conference, National Pan-Hellenic Council, National Association of Latino Fraternal Organizations)

☐ No ☐ Yes

60. How many hours a week do you work for pay?

61. How many hours a week do you volunteer?

62. What is your primary source of health insurance?

63. What is your approximate cumulative grade average?

☐ A ☐ B ☐ C ☐ D/F ☐ N/A

64. Within the last 12 months, have you participated in organized college athletics at any of the following levels?

(Please mark the appropriate column for each row)

Yes
No

65. Do you have any of the following?

(Please mark the appropriate column for each row)

Yes
No

| | |
|---|----|
| Attention Deficit and Hyperactivity Disorder (ADHD) | 00 |
| Chronic illness (e.g., cancer, diabetes, auto-immune disorders) | 00 |
| Deafness/Hearing loss | 00 |
| Learning disability | 00 |
| Mobility/Dexterity disability | 00 |
| Partial sightedness/Blindness | 00 |
| Psychiatric condition | 00 |
| Speech or language disorder | 00 |
| Other disability | 00 |

66. Are you currently or have you been a member of the United States Armed Services (Active Duty, Reserve, or National Guard)?

THANK YOU FOR COMPLETING THIS SURVEY

PAGE TWELVE

SERIAL #

Appendix I

Observational Report

Nia Cohort 11 Session 4

Wednesday, October 1, 2014

Program Setting

Physical Setting/Environment- Outside

The Nia session was held at Bird House, a building located on VCU's Monroe Park campus. greet participants. The only entrance for participants was through the front door, which automatically locked at 6 pm.

Physical Setting/Environment-Inside

When entering the front door, participants were instructed to take a flight of stairs directly ahead of them.. At the top of the stairs, participants were directed the building's conference room. A large computer monitor was mounted on the wall next to the entrance. On the wall directly facing the door, a large paper had the Nia take home message hand written on it: "The decisions you make can affect you, your partner, and the community." The wall to the left side of had windows and computer system was set next to this wall. On the right side of the room, there was a closet. In the center of the conference room consisted of a series of four black tables, which were formed in a square shape. Each table could seat four participants.

Social/human environment

The session was scheduled to begin at 7:00 pm. The male facilitator, went outside around 6:45 to greet participants and unlock the front door. The female facilitator, remained upstairs in the conference room preparing the room. About ten minutes before the session was to begin, the caterer arrived with the food for the session. Around 6:50, participants began to arrive. The female facilitator used Pandora to play music for participants, who ate their sandwiches and socialized before the session began. By 7:05, six participants had arrived. At roughly 7:15 the male facilitator came upstairs to the conference room, stating that the final participant had not arrived. He and his co-facilitator sat down next to each other and chatted with participants about current events. After ten minutes or so, the facilitators formally began the session by summarizing the activities in the last session. They asked participants to mention the activities

they had performed in the previous session, including a condom demonstration with penis models. Several joked about this activity, noting it as extremely awkward. The facilitators also asked participants to summarize what each activity was designed to teach them. After this discussion, the male facilitator laid out the plan for the final session, which was to build skills for making safer sex decisions. This activity consists of the group watching a series of six movie clips depicting risky sexual situations. Each video was designed to become progressively riskier. As six participants arrived to the session, each participant could take a turn. The facilitators would first play each video clip for its full duration. Then the video would be played for a second time, with a participant telling the facilitators where to stop when they had identified a “trigger” for risky sexual behavior. The facilitators and other participants then helped the individual develop a plan to reduce their sexual risk. Most solutions to sexual “triggers” included always having condoms available and limiting one’s alcohol use. The six participants at this session seemed to greatly enjoy this activity, as most recognized the movie clips and enjoyed them. Participants often laughed and joked with each other about their “triggers” but provided positive suggestions for reducing their risk. Following this activity, the facilitators summarized the entire intervention and stressed the importance of Nia’s take home message, “The decisions you make can help protect yourself, your partners, and your community.” Following the summary, post-test data collection occurred. Participants completed surveys in about twenty to thirty minutes. Afterwards, they were provided their incentive. However, many participants did not leave immediately. Most continued to talk to each other or facilitators while others completed surveys.

Observational Comments and Recommendations

This Nia session was well-organized and strongly executed program. A facilitator was waiting outside to allow participants into the building, while another was inside preparing for the session.

The session seemed to be very well received by participants, who were very engaged while it was going on. In particular, participants greatly enjoyed the activity in which they watched movie clips and described how they would handle risky sexual situations. Overall, it seems that this cohort of Nia was very effective. Also, the final discussion with participants lasted far longer than expected. Also, many participants lingered after the session had ended, indicating their strong interest and appreciation for the experience.

Submitted by

Joshua Brevard

Appendix J

Facilitator Interviews

Interviewer: Joshua Brevard

Participants: 2

Interviewer: I just have a couple questions for y'all, um...about your experiences facilitating Sista. Um...the first question is just, looking back on your experiences, do you feel like you were able to um...facilitate Sista with fidelity? Um...in line with the way you all were trained to?

Participant 1: I would say yes. Um...we received the training, I know for me, it was...like a long time ago. But we were implementing the intervention so consistently that I didn't feel like the training had a chance to wear off if that makes sense so...um...and then we were...especially in the beginning...um...Dr. Belgrave and Dr. Tademy were having a lot of meetings and asking for a lot of feedback and I think they were doing the observations and stuff too, so there were a lot of measures taken to make sure we were doing it with fidelity.

Interviewer: Mmmhmm. Okay.

Participant 2: I would agree in terms of the consistency of implementing and then um...for me, I was trained much later. But there wasn't a huge time lag between training and my first session and I think of course, the first session was the toughest session because you're kind of getting acclimated to it. And I think too um...in my case, because I had the same co-facilitator every single time, it was a lot easier and we kind of fell into a swing of okay, so we kind of know how this thing goes and kind of did it, I think, with fidelity each time.

Interviewer: Okay um...so I guess the next question is um...what were any challenges or were there any challenges that you experienced delivering Sista and if so, how did you deal with them?

Participant 2: I would say one challenge is having...when you have a group that there are kind of half or some that are very much talkative and engaged and others that are not, you can kind of see that kind of mess up the dynamic sometimes and you can feel the participants who are very engaged looking at the others like "Are you going to speak up? Are you going to say something?"

Interviewer: Mmmhmm.

Participant 2: And I think as a facilitator, when people aren't engaged you're kind of trying to facilitate but at the same time it's like "Oh my gosh, why are they not engaged? What do I need to do to get them engaged?"

Interviewer: Mmmhmmm.

Participant 2: And sometimes you can and sometimes you can't um...but I think we just would always, when we say it happen, we would remind them participate. We would always remind them that participation was one of the ground rules, that everybody needed to participate. And we would just try to remind them um...and usually that would work and get the people to speak up that hadn't spoken...yeah.

Interviewer: Okay cool...

Participant 1: Yeah...I think that was definitely a challenge for us too. What we would try to do is do the "polling technique" so that everybody has to respond um...to a question. Um...one of the things that I, in hindsight, now that I've seen some of these girls on campus, I realized like "Oh, she's was a lesbian. Or oh, she's a bisexual so that's probably why she wasn't engaged." It's like it...it didn't really appeal to her and it made me think of the differences in recruitment between Sista and Nia. For Nia, we explicitly say men who have sex with women.

Interviewer: Mmmhmmm.

Participant 1: Um...and then for Sista we're just like...women between the ages of this and this, you know? Or...women 18 and over.

Interviewer: Yeah.

Participant 1: Um...so and I definitely think the intervention is for women who have sex with men. But...I don't know if that's something we kind of make plain in the beginning.

Interviewer: Mmmhmm.

Participant 1: Um...I think recruitment wasn't really too challenging, people were usually enthusiastic about participating. Getting people to show up on time, was sometimes challenging. Um...not having a group show up on time...makes you have to start the group late, it makes you have to end late. Which some people get a little...not happy about. And it also makes the facilitators not happy because it's like "Okay, I planned for two hours or two and a half hours for this and then now it's been three and this is cutting into whatever time I had for this." So that was challenging. Um...trying to think. I don't think anything else was really too challenging. Um...it was a good experience overall.

Participant 2: The only other thing I would say is on the flipside of participants who are not very engaged, some participants who like to dominant conversations and talk a lot. Um...and I think sometimes it would be a struggle to kind of move on without those people feeling like you were shutting them down or shut them out of the conversation.

Interviewer: Mmmhmm.

Participant 2: So...I don't know that we had any real strategy that we used but we would just kind of listen and um....remind them, we would remind them a lot of..."I know you have a lot of things to do after the session, so we're going to move a little quicker."

Interviewer: Mmmhmm.

Participant 2: And not really focus it on a person specifically, but we got to move a little quicker so we can get done.

Interviewer: Mmmhmm.

Participant 2: And that would help most of the time. Then of course, sometimes they would want to just keep talking.

Interviewer: Mmmhmm.

Participant 2: But yeah, I think other than those things it was fun.

Interviewer: Yeah.

Participant 2: As a facilitator, it was fun.

Interviewer: Okay, cool. Um...was there anything you would have done differently?

Participant 1: As a facilitator?

Interviewer: Mmmhmm.

Participant 2: Um...I think that I might have loosened up a little sooner and by that I mean, that in the beginning I think you kind of go this facilitator training and you know, I'm facilitating this structured program and I'm accustomed to being a graduate student in this presentation kind of format. And so I would try to be professional and that sort of thing, but then realizing um...kind of as we went through the sessions that it was much more helpful for me and the participants to be, you know, more relatable.

Interviewer: Mmmhmm.

Participant 2: And not try to take this...kind of...let me present this program thing, but meet them on their level kind of thing. And I think having an undergraduate co-facilitator helped me because she was able to relate to them sometimes in ways that I didn't. And so it alerted me to the fact that, "Okay, it's okay to be normal." So yeah...

Interviewer: Okay...

Participant 1: Um...I'm trying to think, it's been a while since I facilitated (laughter). Um...I think one thing we started doing...and this might be a slight adaptation, but we started doing this later and I agree I wish we would have started doing it earlier. Because I think it would have helped with retention better, but giving more opportunities for the girls to talk as a group. Outside of formal intervention stuff. So...like, almost doing some kind of personal icebreaker every session or um...while we're waiting on people to arrive, talking as a group. Um...to find out "How has your week been going? How's that class or how'd you do on that final? How was

that interview?” People, I think, attach more to the group when those kinds of conversations happen. Um...so maybe even just starting a session informally for like five or ten minutes before you actually start with the intervention to establish better rapport.

Interviewer: Okay.

Participant 1: One thing I did notice um...as a facilitator who did a couple of observations for other facilitators, I think in an effort to do that, to be...to establish better rapport, to be more relatable, I noticed that there was some facilitators that did, in my opinion, overshare. And I know in our training, one thing we were taught was...you know, share some things if you think it's appropriate but don't overshare.

Interviewer: Mmmhmmm.

Participant 1: And don't share it if it's like, “Oh, I was sloppy drunk!” And like...that's not the message you're trying to get across, you know?

Interviewer: Mmmhmmm.

Participant 1: And I witnessed some facilitators kind of sharing those kind of stories and I'm like....like that's not, (laughter) as a facilitator, that's not kind of...I think it makes you more human, but at the same time I'm like...I don't know if that's the most appropriate story.

Interviewer: Mmmhmmm.

Participant 1: So kind of...not sharing all your business, maybe some of it, you know. Like...share what you learned or maybe even talk about that story like, “I had a friend who...got sloppy drunk!” (laughter) You know, so it doesn't tear down your credibility.

Interviewer: Yeah.

Participant 1: In the same breath as...making you more relatable.

Interviewer: Okay...um...so, um...how do you think participants benefitted from the intervention?

Participant 2: Um...I can say from both during the intervention....um...sessions...and um...at the follow-up session, participants consistently report working on being assertive rather than aggressive.

Interviewer: Mmmhmmm.

Participant 2: I think that's one...it's funny because the – Sista is kind of set up to be more so about romantic relationships and sex and that sort of thing, but I think that just...relational aspect, not even necessarily in a relationship context or a romantic relationship context, but that aggression-assertiveness thing, they really grab hold on.

Participant 1: Yes.

Interviewer: Mmmhmmm.

Participant 2: And so...they're always coming back and saying, you know, "I've been working on being more assertive."

Interviewer: Mmmhmmm.

Participant 2: So I think they really - a lot of them don't recognize the difference between the two prior to coming um so....

Interviewer: Okay.

Participant 1: I agree...while this particular skill is used for HIV prevention, it actually, for some women...I actually facilitated Sista since I was in graduate school in a homeless shelter. And this woman talked about how that particular session helped her leave an abusive relationship.

Interviewer: Mmmhmmm.

Participant 1: Um...so I feel like it can translate - I mean, other women have talked about leaving, just unhealthy relationships from that particular training or...you know, dealing with a roommate that had some issues or a best friend or whatever. So...I definitely think that assertiveness skills training was um...really helpful. I think women take away a greater pride and self-worth in terms of being an African American woman.

Interviewer: Mmmhmmm.

Participant 1: We do a lot of highlighting of the positives in Sista, so I think that was one thing that people took away....maybe a heightened ethnic identity.

Interviewer: Okay...

Participant 1: In my opinion...gender and ethnic identity.

Interviewer: Okay.

Participant 1: Um...and I also think for some girls it was way for them - especially our freshmen girls, like it's their first time actually getting involved in something at VCU.

Participant 2: Mmmhmm.

Participant 1: For them it was a way to get involved.

Interviewer: Okay.

Participant 2: Um...to kind of piggyback off of the...heightened ethnic and gender identity, I think for some of them...I mean these are young African American women. This is a...sometimes first time, sometimes not first but maybe rare occasion where they are in a room with other young women. And it's for a positive reason, they're relating in a positive way and it's not all of the drama and the things they will talk about that they're used to. Um...and even though I think most of them probably don't keep in contact, if they didn't already know each other coming in, I think when they leave it's definitely a sense of aww...you know, "This was something - I really enjoyed this while it lasted. I made some connections with some people."

Um...and I think that that maybe just makes them feel like they're not alone on this campus, kind of thing. Um...they're other young women around me who look like me, that are going through the same types of things that I'm going through in relationships specifically. And these are things that they may not be talking about outside of Sista. So I think it's a good experience for them to relate to each other in a way that's positive, rather than negative.

Interviewer: Okay.

Participant 1: Also...piggybacking on that (laughter). One unintentional benefit or kind of good consequence of girls participating in Sista, particularly with graduate students as facilitators, in PhD programs...Black women...I think a lot of them were like, "Wow! Like...oh my God!" And some of them wanted to talk afterwards, like "How did you get into grad school? Do you like it? How's this?" And... you know, telling us it's really inspiring and even on some of the evaluations you see like, "It's so cool to see both of you doing this and getting your degrees. Y'all go girl!" You know...whatever (laughter).

Interviewer: Mmmhmm.

Participant 1: So I think that was also an unintended kind of benefit of them like, seeing Black women achieving and doing good things and giving back.

Participant 2: And I guess since then a couple of them have signed up to work as research assistants for Raise 5, student organizations, so yeah...

Interviewer: Okay, that's good. Okay, so I guess...last question. Were there ways that you saw like...um...changes in, I guess like...their risky behaviors or alcohol use? Because I know you did the enhanced Sista and focused on I guess...drinking responsibly and things like that. So did you see any changes um...based off those two versions of the intervention, in their risky behavior in general?

Participant 2: I don't know – I mean, I don't know that I could say I saw changes, I mean I guess hopefully the survey picked up some. But I think from just anecdotally from sessions, I can remember when we would talk about alcohol and particularly when we would do the drinking game and you know, measuring out the drinks, they're minds would be blown at how much alcohol they would be taking in over the course of a night. And then, you know, you would hear crazy stories um...and then there - I remember this was the last cohort that we did, one of the girls – and there's usually, sometimes there's one or two in each of our cohorts where there's a girl that doesn't drink. And the girls will be like, "You don't drink? Like what?" Um...and she's like "Yes, so I'm normally the DD for my group of friends." And so the girls would all kind of like joke around, you know, "Well, we're going to pay her to be our DD!" I don't know if they did that. Um...but they would kind of joke about doing things differently, to be safer in the future. So hopefully they did, but...

Interviewer: Okay.

Participant 1: Yeah...I don't necessarily know that I can attest to actual behavioral changes, but um...either but I...would agree that um...when people saw us playing the game with the alcohol bottles people were like, "Oh my gosh." We got a lot of surprised faces off of that.

Interviewer: Mmmhmmm.

Participant 1: And we also got um...a lot of surprised faces off of the VCU survey, like that data – when people find out the majority of VCU students don't drink or don't smoke weed or don't do pills or whatever. It's like...they were really surprised to learn that information.

Interviewer: Okay.

Participant 1: One thing that I think we could have done better with that though, is almost like um...maybe do some specific assertiveness skills training on that note, particularly with regard to like saying no or saying no to alcohol or drugs or...knowing to like...say, "I've had enough." You know what I'm saying? Like, "Oh I'm good!" You know what I'm saying? Like, "I'm not trying to be throwing up tomorrow and blacked out and not remembering what the hell happened to me, you know? I'm good right now, where I am." Um...that was one thing that I wish we had kind of taught them, because I still feel like even though people know like, "Oh, these are the stats and this is how much alcohol is in an actual drink," I still feel like maybe they didn't know how to...handle specific situations that they might find themselves in at parties or clubs or somebody's house.

Interviewer: Okay.

Participant 2: And specifically outside of a...kind of potential...sex situation. Because there were plays where it would be like, you know, you were in a situation where, "Are you going to drink? Are you not going to drink?" And there are people having sex and how does that impact that?

Interviewer: Mmmhmmm.

Participant 2: But I mean...you're not dealing with - you know, there are girls who are hanging with their female friends prior to going out. And those are the friends who might be, you know, pressuring you.

Participant 1: Pressuring you, yeah.

Participant 2: Like you need to say something to them so...

Interviewer: Mmmhmmm.

Participant 2: I think that's a probably true...

Participant 1: Or just out at the club and...I think there's a ton of pressure from peers in addition to pressure from somebody, maybe, you're trying to have sex with. But...

Interviewer: Mmmhmmm.

Participant 1: The pressure, just from peers that might lead to an unwanted sexual experience because you no longer have any control of your agency, your sense of agency.

Interviewer: Mmmhmmm. Okay, so do y'all have any final thoughts on your time facilitating Sista?

Participant 2: I love Sista. I'm sad to not be doing it anymore (laughter).

Participant 1: I can say um...as a participant of Sista, I definitely think it has changed the way...like, I approach sexual situations.

Interviewer: Mmmhmmm.

Participant 1: Like, after I participated in Sista I was always like...condoms in my purse! (laughter). You know, and I felt very confident about like, I know how to put a condom on. Like, I don't have to be like, "Oh, no! You do it! I don't know how to do that! That's your thing!" You know? No, I know I like these types of condoms and I know this kind of lube is the lube to buy. I know – like it made me feel, I don't know, more of a woman, I think. Um...and more in control of my body and...it also made me feel like, much more confident going into sexual situations in terms of protecting myself.

Interviewer: Mmmhmmm.

Participant 1: Because I think before that, I felt like I was at the mercy of whoever I was dealing with (laughter). Like, "Oooh, I hope he used one!" You know, like – but then it was like, no, like I can say that one is going to be used like, and yes it will be used. Or nothing goes down and I don't have to feel like crap if it doesn't.

Interviewer: Mmmhmmm.

Participant 1: So...yeah. I think um...it's been really important for me in that way and I imagine for other people too. One thing I do...I know Sista hasn't really tapped into it and we started a little bit with it, like trying to Facebook stuff.

Interviewer: Mmmhmmm.

Participant 1: I think incorporating some kind of...digital something in Sista would be...really good. Because we're dealing with you know, Millennials who...that's all they know, you know?

Interviewer: Yeah.

Participant 1: And for the intervention - it's pretty old...

Interviewer: Yeah.

Participant 2: I think too, it might be better to start that in the beginning. So like, if you had a Facebook group that was running from the time the session started, so I mean...you could even be using that Facebook group, they could be posting questions if a question came up and we could go there. And then it's more likely for them to continue it versus the way we do it, it's like they're running out the door. "Okay! We'll see you on the Facebook group!" (laughter)

Participant 1: Yes! (laughter). I agree.

Participant 2: Instagram has been a little more successful, I've found, with them.

Participant 1: I agree, yeah.

Participant 2: But um....I think starting it sooner rather than later would help.

Interviewer: Okay, yeah. Well thank you for your time.

Interviewer: Joshua Brevard

Participants: 1

Interviewer: I have a couple questions about your experience facilitating Nia. Looking back on...doing Nia, do you feel like you were able to...deliver it with fidelity?

Participant: Um...honestly we switched it up towards the end.

Interviewer: Mmmhmmm.

Participant: Like...when the groups were bigger, we would do less on the first session, like only the icebreaker game.

Interviewer: Mmmhmmm.

Participant: Or we would have to like shorten the part where we did the movie clips. Like, instead watching all six movie clips, we would only watch like...three clips.

Interviewer: Mmmhmmm.

Participant: So we would change it...depending on the size of the group.

Interviewer: Okay. Um...do you feel like, I guess, despite the changes that you made, the intervention as delivered the way it was intended to be delivered.

Participant: Yeah.

Interviewer: Okay. Um...so then, the next thing is what were any like challenges or complications that you experienced facilitating Nia?

Participant: I mean, the major thing was always whether we were going to have enough people.

Interviewer: Mmmhmmm.

Participant: It was also...um, getting people to come back every week. That was a big challenge.

Interviewer: Okay, so the biggest issue was trying to get enough people to participate in the first place and then keeping guys once they were there....that was the big challenge?

Participant: Mmmhmm.

Interviewer: Okay...was there anything you did in particular to...um, address those issues?

Participant: Um...we would call people. Um...like with the sign in, we would get an old sign in sheet and try to call or text the people that were missing.

Interviewer: Mmmhmm. Okay....was that generally successful?

Participant: I wouldn't say it made a major impact. Because honestly, the people who wanted to come, those were the ones that came. And like...if they were missing and we would call or text them, they wouldn't answer or reply. But that didn't happen too often. I think...it really got difficult towards the end, like when, I guess recruiting got harder.

Interviewer: Mmmhmm.

Participant: Like...early on, people would come and they would return, because they like, enjoyed it. But I would say that probably like three...three or four times, we would have to like call people.

Interviewer: So...there were eleven cohorts. Three or four of those cohorts you had to call people?

Participant: Mmmhmmm.

Interviewer: Okay. And these were generally cohorts towards the end?

Participant: Well...so I would put it like, overall, three or four of them, out of the eleven, three or four times, we had to like call people to remind them to come back. But towards the end, it just...I would say for the last two cohorts, I think it was, when like, we didn't have enough people. Like...so...it wasn't that we had to call people, it was that we started with like three people.

Interviewer: Mmmhmm.

Participant: So...we'd start off with however many, I can't remember off the top of my head, but I know it was a small number.

Interviewer: Okay...and you feel like, with having a smaller group...you're not able to – the intervention doesn't flow the way it should? When there's a group of three guys opposed to like six or seven, right?

Participant: Right. And it was designed for – it wasn't designed for like, three people.

Interviewer: Okay. So...do you feel like you experienced anything that was difficult in your role, being the only woman in the group? And having to provide or speak up for that perspective?

Participant: Um...no, that was one of my favorite parts...getting a chance to um, a lot of the time, the guys that would come through...like, they wouldn't have opportunities to have these types of conversations with...men, let alone with a woman to provide her input. So it wasn't challenging, it was more...like rewarding, I felt like it was the best part.

Interviewer: Okay. Um...so just looking back, how do you think the guys who participated, how do you think they benefitted from Nia?

Participant: I think the basic knowledge...um, we did a lot of myth busting, so they learned...I think overall they learned a lot more about HIV and um...STIs in general. Um...I think for

some of them, I won't necessarily say...I think it started – gave them a confidence to have these conversations. Like, with other men in their lives, whether it be friends or family.

Interviewer: Mmmhmmm.

Participant: A lot of them would talk about how...um, they were able to integrate it into their normal lives. Like, they would come back and say, "Oh yeah, my friends were talking about condoms, and I was able to tell them about expiration dates." Little stuff like that. Um...so it gave them, like it empowered them to use what they were learning practically.

Interviewer: Mmmhmmm. So, do you feel like most guys came away with something? Or were there a lot of participants who were just there to get paid?

Participant: I would say for the most part, everyone was engaged. There were maybe – there were a few people that never spoke. I mean, I don't know numbers off the top of my head, but I would probably say through all the cohorts combined, there were probably only about five or six guys who never spoke. They were just there, it seemed like, to get the money. But for the majority, people would participate and they were engaged and they gave us feedback that if nothing else, they learned about HIV in particular and um...when it came to like, um...like the transmission - modes of transmission. And then information about condoms and like stuff, tips on how to use them more or um...make them more...appealing to use with their partner and how to bring up conversations about using condoms with their partner.

Interviewer: Mmmhmmm. Okay...so for the guys who didn't talk or weren't engaged, did you all try to get them involved?

Participant: Yeah, we would try. Like...we would try to ask them questions or I would say, "How about we hear from the people who haven't spoken yet?" Um...sometimes it worked, sometimes it didn't.

Interviewer: Okay...do you have any final thoughts on your time facilitating Nia?

Participant: I mean...well I would say that I feel like Nia was successful in educating people about HIV and in regard to generating conversation. I feel like they were the two most important parts of Nia and I feel like most of the guys, the majority of the guys who went through this program got that out of it.

Interviewer: Okay, great. Thank you.

Appendix K

Intervention Feedback Evaluations

Evaluation for Session 1

Please take a moment to rate how effective we were in presenting information to you today.

Below are a number of statements. Please rate each statement on a scale from 1-5, where "1" means we did a poor job and "5" means we did an excellent job.

| Statements: | | Rating |
|-------------|---|--------|
| 1. | I am confident I can communicate more effectively. | |
| 2. | I am confident I can start a discussion about condom use with my partner. | |
| 3. | I am confident I can protect myself from AIDS. | |
| 4. | I feel I got a lot out of the video discussion. | |
| 5. | Any questions I had were clearly answered. | |
| 6. | The videos were helpful. | |

7. Overall, how would you rate the performance of the group leaders? Please circle a number.

| Poor | | Okay | | | | | | Excellent | |
|------|---|------|---|---|---|---|---|-----------|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

8. Overall, how would you rate today's session? Please circle a number.

| Poor | | Okay | | | | | | Excellent | |
|------|---|------|---|---|---|---|---|-----------|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

9. How could this session be improved?

| |
|--|
| |
|--|

10. Was any of this information new to you? Any surprises?

Questions to answer on back of page.

11. As a result of this session, I will make some positive changes in my life.

☐ Yes

☐ No

12. Any other comments?

Thank You!

Evaluation for Session 2

Please take a moment to rate how effective we were in presenting information to you today.

Below are a number of statements. Please rate each statement on a scale from 1-5, where “1” means we did a poor job and “5” means we did an excellent job.

| Statements: | | Rating |
|-------------|---|--------|
| 1. | I am confident I can communicate more effectively. | |
| 2. | I am confident I can start a discussion about condom use with my partner. | |
| 3. | I am confident I can apply this knowledge to my future sexual relations. | |
| 4. | The demonstrations were helpful. | |
| 5. | Any questions I had were clearly answered. | |
| 6. | The videos were helpful. | |

7. Overall, how would you rate the performance of the group leaders? Please circle a number.

| Poor | | Okay | | | | | | Excellent | |
|------|---|------|---|---|---|---|---|-----------|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

8. Overall, how would you rate today’s session? Please circle a number.

| Poor | | Okay | | | | | | Excellent | |
|------|---|------|---|---|---|---|---|-----------|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

9. How could this session be improved?

10. Was any of this information new to you? Any surprises?

Questions to answer on back of page.

11. As a result of last week's session, I made some positive changes in my life.

☐ Yes

☐ No

☐ Did not attend last week's session

If you checked yes, please describe below the changes you made.

12. Any other comments?

Thank You!

Evaluation for Session 3

Please take a moment to rate how effective we were in presenting information to you today.

Below are a number of statements. Please rate each statement on a scale from 1-5, where “1” means we did a poor job and “5” means we did an excellent job.

| Statements: | | Rating |
|-------------|--|--------|
| 1. | I am confident I can communicate more effectively. | |
| 2. | <i>Answering Your Questions about AIDS</i> is helpful. | |
| 3. | I feel I got a lot out of the role-play situations. | |
| 4. | Any questions I had were clearly answered. | |
| 5. | The videos were helpful. | |

6. Overall, how would you rate the performance of the group leaders? Please circle a number.

| Poor | | Okay | | | | | | Excellent | |
|------|---|------|---|---|---|---|---|-----------|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

7. Overall, how would you rate today's session? Please circle a number.

| Poor | | Okay | | | | | | Excellent | |
|------|---|------|---|---|---|---|---|-----------|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

8. How could this session be improved?

9. Any other comments?

Questions to answer on back of page.

10. As a result of last week's session, I made some positive changes in my life.

☐ Yes

☐ No

☐ Did not attend last week's session

If you checked yes, please describe below the changes you made.

Thank You!

Evaluation for Session 4

Please take a moment to rate how effective we were in presenting information to you today.

Below are a number of statements. Please rate each statement on a scale from 1-5, where “1” means we did a poor job and “5” means we did an excellent job.

| Statements: | | Rating |
|-------------|---|--------|
| 1. | I am confident I can communicate more effectively. | |
| 2. | I am confident I can start a discussion about condom use with my partner. | |
| 3. | I am confident I can apply what I’ve learned and be safer when it comes to my sexual behaviors. | |
| 4. | I feel I got a lot out of the role-play situations. | |
| 5. | Any questions I had were clearly answered. | |
| 6. | The videos were helpful. | |
| 7. | The book, <i>Answering Your Questions about AIDS</i> , was helpful. | |

8. Overall, how would you rate the performance of the group leaders? Please circle a number.

| Poor | | | Okay | | | | Excellent | | |
|------|---|---|------|---|---|---|-----------|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

9. Overall, how would you rate today’s session? Please circle a number.

| Poor | | | Okay | | | | Excellent | | |
|------|---|---|------|---|---|---|-----------|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

10. How can these sessions be improved?

11. Any other comments?

Questions to answer on back of page.

12. As a result of last week's session, I made some positive changes in my life.

☐ Yes

☐ No

☐ Did not attend last week's session

If you checked yes, please describe below the changes you made.

Thank You!

Vita

Joshua Kyle Brevard was born on April 25, 1989 in Columbia, South Carolina. He graduated from Warwick High School, Newport News, Virginia in 2007. He received his Bachelor of Science in Psychology from Virginia Commonwealth University in 2011 and his Master of Science in Psychology from Virginia Commonwealth University in 2013.